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Ref. No 433433 01/017225.0000

October 27, 2005

***VIA HAND DELIVERY***

James T. Odiorne, Esq.  
Deputy Insurance Commissioner  
Company Supervision Division  
Office of Insurance Commissioner  
5000 Capitol Boulevard  
Tumwater, WA 98512

**Re: UnitedHealth Group, Inc. Acquisition of PacifiCare of Washington, Inc.  
Confidential Documents**

Dear Mr. Odiorne:

Enclosed under cover of this letter are the following documents requested in your letter dated October 17, 2005:

- (1) Copies of Market Conduct Examinations Completed in the Last Five Years for Any UGH Affiliate and Official Correspondence; and,
- (2) Copy of Redacted Hart-Scott-Rodino Notification and Report Form filed on October 18, 2005.
- (3) With respect to copies of Internal Testing Reports and Public Accountants' Workpapers for Goodwill which were also requested, we are unable to provide the Department with Deloitte & Touche, LLP's ("D&T") workpapers for goodwill and other intangible assets due to internal regulations at D&T that limit the release of their workpapers. However, please find enclosed a copy of UnitedHealth's internal testing reports for its goodwill and other intangible assets at December 31, 2004, which are provided on a confidential basis. These analyses were provided to D&T during their audit of UnitedHealth's December 31, 2004 financial statements. Also enclosed please find a copy of the unqualified opinion issued by D&T on UnitedHealth's December 31, 2004 consolidated financial statements (which is not confidential).

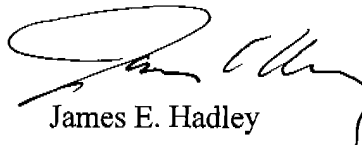
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James T. Odiorne, Esq.  
Deputy Insurance Commissioner  
Company Supervision Division  
Office of Insurance Commissioner  
October 27, 2005  
Page 2

The information contained in documents referred to in subparagraphs (1), (2) and (3) above, which are stamped confidential, is unique to and proprietary with each of the companies respectively identified therein. These documents and the information contained therein are entitled to all protection from disclosure of dissemination to the public under applicable State and Federal laws including, but not limited to, Chapter 42.17 RCW and Title 48 RCW. Furthermore, these documents are specifically protected against public inspection and copying by the public, and are not subject to disclosure, even under subpoena, pursuant to RCW 48.31C.130. Accordingly, and because of the sensitive and private nature of this information, we expect that the Office of Insurance Commissioner shall keep and maintain these documents strictly confidential and not available for disclosure to the public.

The documents not bearing confidentiality stamps are public and not subject to the limitations set forth in the preceding paragraph.

Very truly yours,



James E. Hadley

JEH:nlm

Enclosures

cc: *Via Facsimile Only:*  
Michael McDonnell (w/o encl.)  
Nancy Monk (w/o encl.)  
Bob Sullivan (w/o encl.)  
Joseph Verdesca (w/o encl.)  
Thomas Roberts (w/o encl.)  
Jeffrey Gingold (w/o encl.)  
Erik K. Brue, Esq. (w/o encl.)  
Christopher Machera (w/o encl.)

**REPORT OF EXAMINATION**

**OF**

**UNITED HEALTHCARE OF  
ALABAMA, INC.**

**AS OF**

**DECEMBER 31, 2001**

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STATE OF ALABAMA  
COUNTY OF JEFFERSON

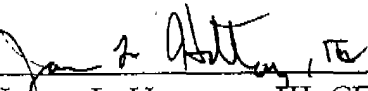
James L. Hattaway, III, being first duly sworn, upon his oath deposes and says:

THAT he is an examiner appointed by the Commissioner of Insurance for the State of Alabama;


THAT an examination was made of the affairs and financial condition of UNITED HEALTHCARE OF ALABAMA, INC., for the period from January 1, 2000 through December 31, 2001;

THAT the following 99 pages constitute the report to the Commissioner of Insurance of the State of Alabama; and

THAT the statements, exhibits and data therein contained are true and correct to the best of his knowledge and belief.

  
James L. Hattaway, III, CFE  
(Examiner-in-Charge)

Subscribed and sworn to before the undersigned authority this 17th day of February 2004.

  
(Signature of Notary Public)

Mary Anne Flynn, Notary Public  
(Print Name of Notary Public)

in and for the State of Alabama

NOTARY PUBLIC STATE OF ALABAMA AT LARGE  
MY COMMISSION EXPIRES: Aug 30, 2007  
BONDED THRU NOTARY PUBLIC UNDERWRITERS



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GOVERNOR

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JIMMY W. GUNN

Birmingham, Alabama  
February 13, 2004

Honorable Walter A. Bell  
Commissioner of Insurance  
State of Alabama Department of Insurance  
201 Monroe Street, Suite 1700  
Montgomery, Alabama 36130-3351

Dear Commissioner Bell:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions of the National Association of Insurance Commissioners, an examination as of December 31, 2001, has been made of the affairs, financial condition, and market conduct of **United HealthCare of Alabama, Inc.** at its home office located at 3700 Colonnade Parkway, Birmingham, Alabama 35243. The report of examination is submitted herewith.

Where the description "Company" appears herein, without qualification, it will be understood to indicate United HealthCare of Alabama, Inc.

## **SCOPE OF EXAMINATION**

The Company was last examined for the three-year period ended December 31, 1999. The current examination covers the two-year period from January 1, 2000 through December 31, 2001, and was conducted by examiners representing the State of Alabama Department of Insurance. Where deemed appropriate, transactions subsequent to December 31, 2001, were reviewed.

The Company was to be examined in accordance with the statutory requirements of the Alabama Insurance Code and the regulations and bulletins of the Alabama Department of Insurance; in accordance with the applicable guidelines and procedures promulgated by the National Association of Insurance Commissioners (NAIC); and in accordance with generally accepted examination standards.

The discussion of assets and liabilities contained in this report has been confined to those items which indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attests to have valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2001. A signed letter of representation was also obtained at the conclusion of the examination whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, financial position of the Company, and contingent liabilities.

The Company's financial statements, as reported by the Company in its filed Annual Statements, are included on pages 97-99 of this report.

The market conduct portion of the examination consisted of a review of the Company's territory, plan of operation, policy forms, rates and underwriting practices, advertising and marketing, treatment of policyholders and claimants, and compliance with agents' licensing requirements.

## **ORGANIZATION AND HISTORY**

The information contained in this section of the examination report was excerpted from prior examination reports and updated as appropriate.

The Company was founded in April 1985, as a joint venture between the Medical Advancement Foundation, an affiliate of the University of Alabama Health Sciences Foundation, and certain individual businessmen. Under the laws of the state of Alabama, the Company was incorporated on July 16, 1985, as "Complete Health, Inc.," a for-profit health maintenance organization (HMO).

On November 15, 1989, with the approval of the Alabama Department of Insurance, the shareholders of the Company transferred their stock to United HealthCare South, Inc. (formerly known as Complete Health Services, Inc.), thereby making the Company a wholly-owned subsidiary of United HealthCare South, Inc. (UHC-South).

A change in the ultimate control of the Company occurred in May of 1994, when UHC-South, the parent, merged with United HealthCare Corporation (UHC Corp). On April 30, 1996, United HealthCare Services, Inc. (UHS), an HMO management corporation and a wholly-owned subsidiary of UHC Corp, purchased UHC-South for its net book value from UHC Corp. UHS became the sole shareholder of UHC-South.

Effective May 1, 1996, the name of the Company was changed from "Complete Health, Inc." to the current "United HealthCare of Alabama, Inc." Also on that date, the Company's wholly-owned subsidiary, Complete Health of Alabama, Inc., changed its name to "United HealthCare of Alabama-FQ, Inc." (UHC AL-FQ).

On January 2, 1998, UHC-South merged into UHS, whereby UHS became the sole shareholder of the Company.

On December 31, 1998, UHC AL-FQ merged into the Company, with the Company being the surviving entity. Since the Company and UHC AL-FQ were under common control, the transaction was accounted for as a "pooling of interest."

As of June 30, 2000, UHS contributed its common stock of the Company to United HealthCare, Inc.

At December 31, 2001, the Company's Annual Statement reflected outstanding capital stock totaling \$121,978, which consisted of 927,074 shares of common stock of \$.11 par value and 2,000,000 shares of \$.01 par value preferred stock. In addition to the capital stock, the Company reported \$17,561,870 of gross paid in and contributed surplus, \$41,307,833 of unassigned funds (surplus) and \$(56,250) of treasury stock.

## **MANAGEMENT AND CONTROL**

### ***Stockholders***

As of December 31, 2001, United HealthCare, Inc. owned 927,074 shares of the common voting stock of the Company, representing 100% of the common voting stock of the Company, issued and outstanding. Fifteen thousand shares were held as treasury stock. -

The Company also had 2,000,000 shares of preferred stock issued and outstanding, all of which were owned by UnitedHealthcare, Inc.

### ***Board of Directors***

The By-Laws of the Company provided that its business and affairs shall be managed by the Board of Directors having no less than five and no greater than 17 directors.

On March 3, 2001, the following directors were elected in a written action in lieu of the annual meeting of the sole shareholder, and were serving at the examination date:

| <b><u>Name/Residence</u></b>              | <b><u>Principal Occupation</u></b>                            |
|---|---|
| Brian K. Beutner<br>Minnetonka, Minnesota | Secretary<br>United HealthCare Corporation                    |
| William A. Munsell<br>Edina, Minnesota    | Chief Administrative Officer<br>United HealthCare Corporation |
| Charles C. Pitts<br>Birmingham, Alabama   | Chief Executive Officer<br>United HealthCare Corporation      |

Robert J. Sheehy  
Edna, Minnesota

Vice President, COO  
United HealthCare Corporation

John A. Wickens  
Brentwood, Tennessee

Senior Vice President  
United HealthCare Corporation

### ***Officers***

Officers elected by a written action in lieu of an annual meeting of the Board of Directors, and serving at December 31, 2001, were as follows:

| <u>Officers</u>        | <u>Title</u>  |
|------------------------|---|
| Charles C. Pitts       | Chairman and Chief Executive Officer                |
| Jack Wickens           | President -   |
| William A. Munsell     | Vice President and Assistant Treasurer              |
| Gary C. Baker          | Chief Financial Officer                             |
| Allan J. Weiss         | Treasurer   |
| David J. Lubben        | Assistant Secretary                                 |
| Diane L. Flottemesch   | Vice President - Taxes                              |
| John W. Kelly          | Vice President - Tax Services                       |
| James W. Fielder, Jr.  | Chief Operating Officer                             |
| Larry B. Amacker, M.D. | Senior Medical Director                             |
| Rhonda R. Bagby        | Vice President - Finance and Network<br>Development |
| Daniel J. McAthie      | Vice President - Finance and Assistant<br>Treasurer |

### ***Committees***

The Company's Board of Directors, through the quality improvement program, appointed the members of the Executive Oversight Committee (EOC), with the Chief Executive Officer as the chairperson.

It was determined that the Company appointed individuals other than members of the Board of Directors to serve on the Executive Oversight Committee, which is in violation with ALA. CODE § 10-2B-8.25 (1975), which states that:

"Unless the articles of incorporation or bylaws provide otherwise, a Board of Directors may create one or more committees and appoint members of the

Board of Directors to serve on them. Each committee may have one or more members, who serve at the pleasure of the Board of Directors."

The EOC then appointed a variety of committees to review and facilitate health maintenance organization operations within the holding company system. Below is a listing of the Company's committees and the positions that comprise them:

- Executive Oversight Committee:
  - CEO (Chair)
  - Sr. Medical Director
  - VP of Health Services
  - Manager of Medicare
  - Director of Physician Services
  - VP of Sales
  - VP of Operations
  - Manager of Provider Relations
  - Compliance Officer
  - Director of Quality Improvement (QI)
- Alabama Peer Review Committee
  - Medical Director
  - Permanent Care Physician (PCP) Members (3) (1 of the PCP or Specialists will be the chair)
  - Specialist Physician Members (3)
  - Compliance Officer
  - Provider Information Management
  - Manager of Provider Relations
  - Director of Quality Improvement
- North Alabama Credentialing Committee
  - Medical Director
  - PCP Physician Members (3) (1 of the PCP or Specialists will be the chair)
  - Specialist Physician Members (3)
  - Compliance Officer
  - Manager of Provider Relations
  - Director of Quality Improvement
- Gulf Coast Credentialing Committee
  - Medical Director
  - PCP Physician Members (3) (1 of the PCP or Specialists will be the chair)

- Specialist Physician Members (3)
- Compliance Officer
- Manager of Provider Relations
- Health Services Management Committee
  - CEO
  - VP of Health Services
  - Compliance Officer
  - Medicare Product Manager
  - Medical Director
  - VP of Sales
  - VP of Operations
  - Director of Quality Improvement
  - Participating Plan Physicians (7)
- Service Management Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Quality Improvement
  - Alabama Business Unit manager
  - Manager of Provider Relations
  - Consumer Affairs Representative
  - Personal Service Specialist (PSS) Manager
  - VP of Health Services
  - Continuous Quality Improvement (CQI) Manager
  - Medicare product Manager
- Policy and Procedure Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Provider Information Management
  - Director of Quality Improvement
  - General Manager of Claims and Customer Service
  - Alabama Business Unit manager
  - Manager of Provider Relations
  - Claims/Cost Containment Manager
  - Manager of Case Management
  - Supervisor of Compliance and Consumer Affairs
  - Medicare Product Manager

- Compliance Committee
  - CEO
  - VP of Operations
  - Director of Physicians Services
  - VP Sales & Marketing
  - VP Health Services
  - Director of QI
  - VP Government Programs
  - Compliance Officer / Director of Provider Information Management
  - Director of Finance
  - Manager Human Resources (HR)
  - Manager Provider Relations (PR)
  - Manager Information System and Technology (IS&T)
  - Director Claims Operations
  - Senior Medical Director
- Delegated Activities Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Provider Information Management
  - Director of QI
  - Director of Claims and Customer Service
  - Alabama Businesses Unit Manager
  - Manager of Provider Relations
  - Claims/Cost Containment Manager
  - Manager of Case Management
  - Supervisor of Compliance and Consumer Affairs
  - Medicare Product Manager
  - Medical Director (Chair)
- Commercial Formal Complaint Committee
  - Formal Complaint Committee Supervisor (Chair)
  - Medical Director
  - Customer Service/Claims Manager or designee
  - Compliance Officer
  - Marketing VP of Operations
- Medicare Consumer Affairs Review Committee
  - Consumer Affairs Supervisor
  - Medical Director
  - Customer Services/Claims Manager or designee

- Medical Management Manager or designee
- Director of Utilization Management or designee
- Medicare Product Manager or designee
- Compliance Officer or designee

The committees listed above reported either directly or through committees to the Executive Oversight Committee (EOC).

The review of corporate minutes indicated the adoption and approval of numerous committee reports, which appeared to accurately reflect the recommendations and actions of the various committees.

### ***Conflict of Interest***

The Company had an established procedure for the disclosure of any outside interests, memberships, associations and/or affiliations an individual may have as a director, officer and/or key management personnel. The Conflict of Interest Policy was established in the By-Laws. On March 15, 1997, an updated version of the existing policy was adopted by the Board of Directors. Questionnaires were completed annually by all relevant individuals, then reviewed and approved by the Board of Directors. A review of the statements signed during the examination period did not disclose any conflicts.

It was noted that all of the directors and some of the officers served as an officer and/or director of various entities affiliated with the Company's parent, UnitedHealthcare, Inc.

## **CORPORATE RECORDS**

The Company's Certificate of Incorporation and By-Laws (restated May 26, 1998) were inspected and found to provide for the operation of the Company in accordance with usual corporate practices.

Records of the meetings and actions of the Stockholder, Board of Directors and various committees, since December 31, 1999, were reviewed.

There were no changes to the Company's Certificate of Incorporation or By-Laws during the two-year examination period.

## **HOLDING COMPANY AND AFFILIATE MATTERS**

### ***Holding Company – Data Ownership***

The Information Technology Services Agreement, as of June 1, 1996, between United Healthcare Services, Inc., an affiliate of the Company, and Unysis Corporation, Article 16.01 states "The UHS Data is and shall remain the property of UHS and its Affiliates." This agreement gives ownership of the "UHS Data" to UHS and its affiliates, but it does not give sole ownership of the Company's data to the Company.

The Information Technology Services Agreement, as of November 1, 1995, between Metra Health, now known as United HealthCare Insurance Company, an affiliate of the Company, and Integrated Systems Solutions Corporation Article 16.01 states "The Metra Health Data is and shall remain the property of Metra Health and its Affiliates." This agreement gives ownership of the "Metra Health Data" to Metra Health and its affiliates, but it does not give ownership of the Company's data to the Company.

### ***Holding Company Registration***

The Company was not subject to *the Alabama Insurance Holding Company Regulatory Act*, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally, HMOs are subject to regulation in regard to changes in control, but are not subject to the continuing holding company reporting requirements that apply to insurance companies.

The Company has been a member of a holding company system since 1989, when the former Complete Health Services, Inc. acquired it.

United HealthCare Services (UHS) was the sole shareholder of the Company until June 30, 2000, when pursuant to regulatory approval granted on June 15, 2000 by the Alabama Department of Insurance, United HealthCare Services, Inc. transferred its ownership interest in the Company to United Healthcare, Inc., a Delaware general business corporation and a wholly owned subsidiary of United HealthCare Services, Inc. United HealthCare Services, Inc. owns, directly and indirectly, numerous health care companies nationwide. The ultimate controlling entity of the general business holding company system is UnitedHealth Group Incorporated (formerly known as United HealthCare

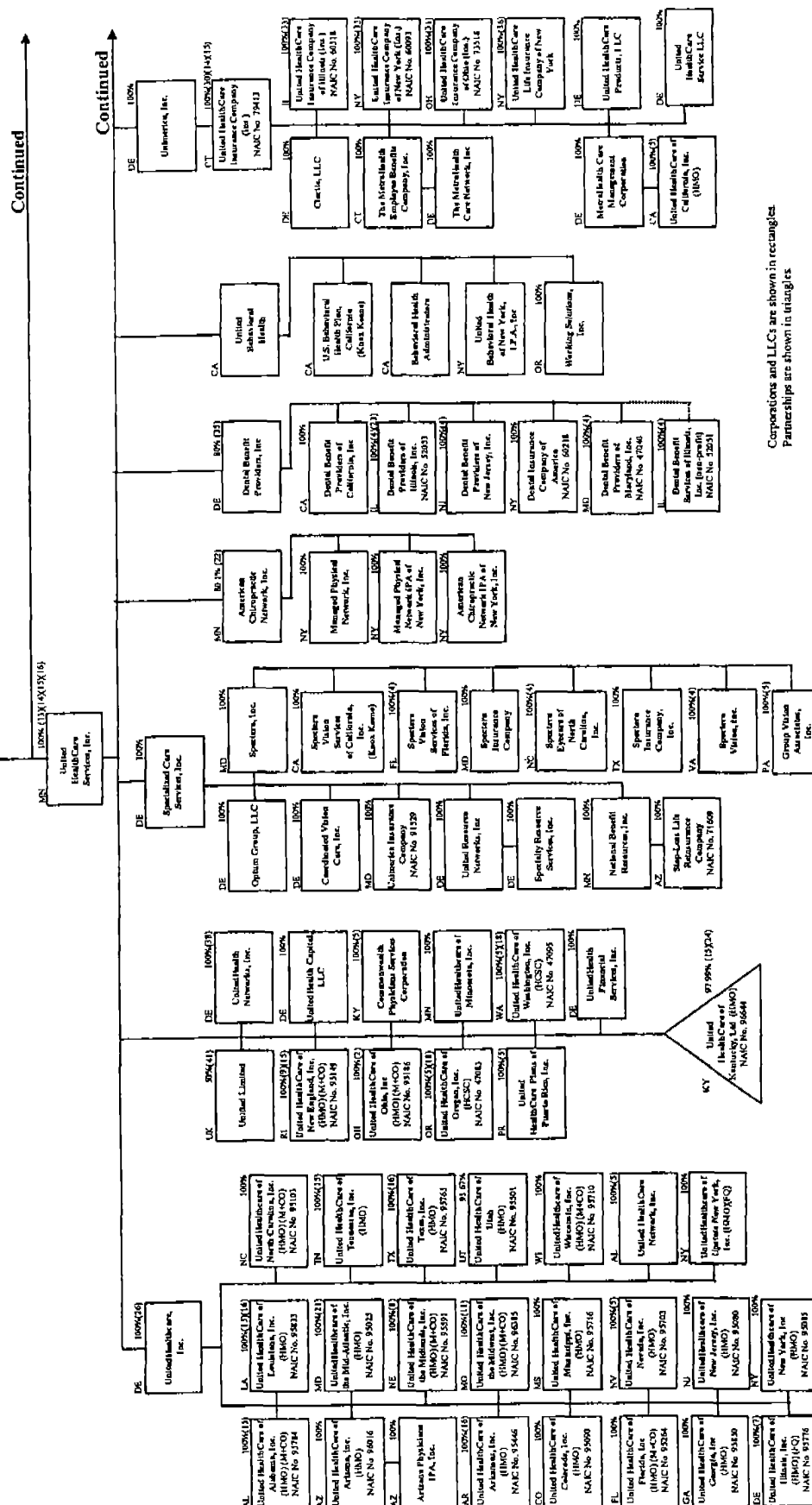
Corporation). UnitedHealth Group has several segments with companies engaged in different kinds of business and does not regard its primary business as health care or life and health insurance. UnitedHealth Group, through its family of companies, has four major businesses, according to Associate General Counsel:

"Uniprise is the nation's leading provider of benefit delivery and service solutions for large, multi-location employers and insurers. Health Care Services includes the businesses of UnitedHealthcare [health benefit plans and services for small and mid-sized employers], AmeriChoice[network based benefit offerings and personal care management programs for individuals in state-sponsored health care programs, like Medicaid], and Ovations [variety of products and services for the health and well-being needs of individuals age 50 and older]. Specialized Care Services operates [numerous] freestanding businesses, each of which has product and services capabilities dedicated to serving a unique area of health care. Ingenix is an international leader in the field of health care data analysis and application."

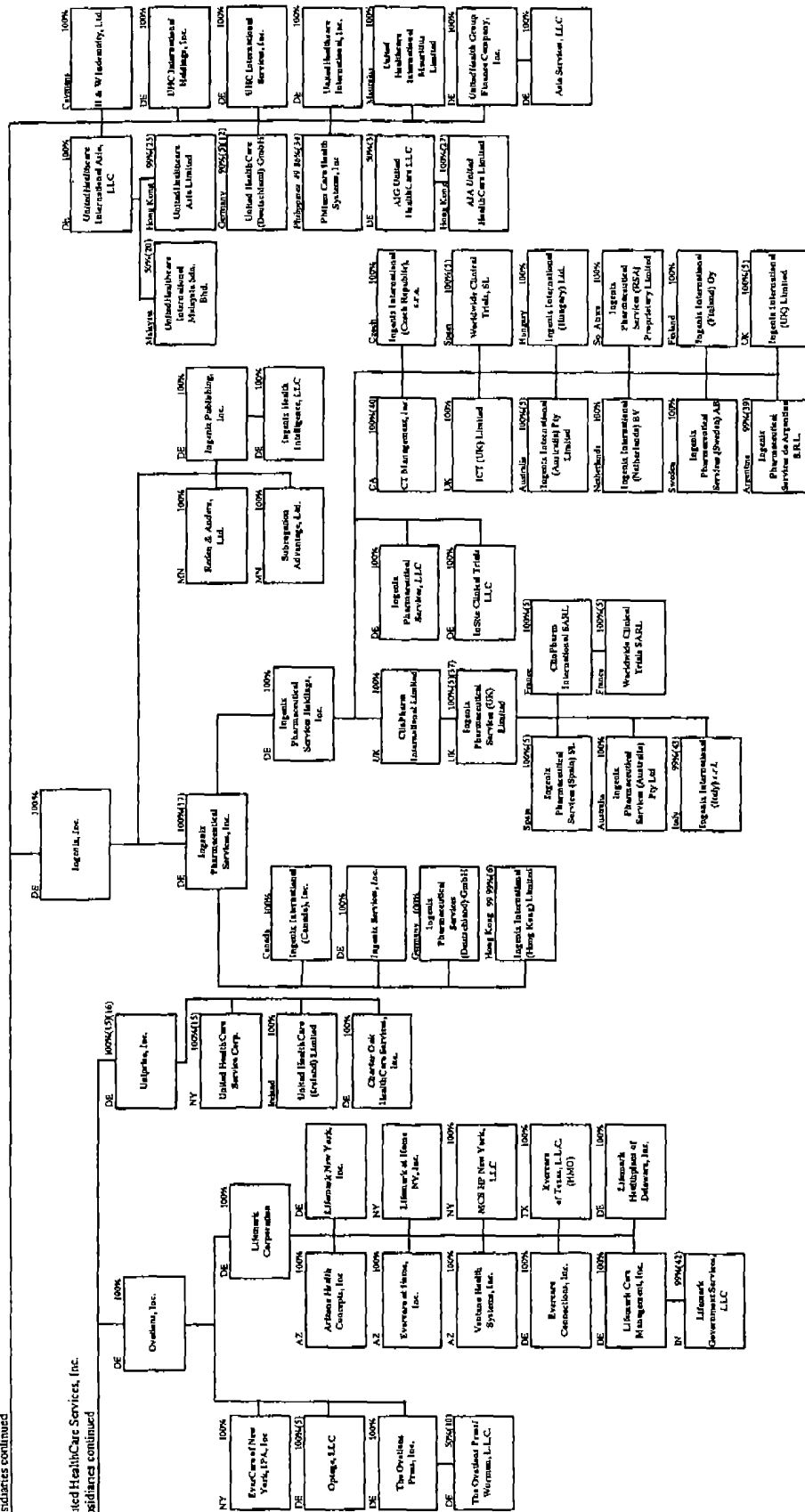
A detailed description of the various corporate changes since the Company's inception may be found under the heading "ORGANIZATION AND HISTORY," in this report.

### *Organizational Chart*

The following chart presents the identities of and inter-relationships among all affiliated persons within the Insurance Holding Company System at December 31, 2001.



Corporations and LLCs are shown in rectangles.  
Partnerships are shown in triangles.



- (1) **UnitedHealth Group Incorporated ("UHG")** (d/b/a UnitedHealth Group) is a Minnesota corporation whose shares of common stock are listed on the NYSE (i.e., it is publicly held). Name was changed from United HealthCare Corporation on March 6, 2000. It only does business in MN. It is the ultimate parent company of all the other UnitedHealth Group entities. It is not licensed as anything, i.e., it is not an HMO, insurance company, TPA, PPO, etc. It is a holding company. It should not be the party to any contract except for certain limited situations. This is not the entity that (i) manages or directly owns the HMOs (that is, for the most part, United HealthCare Services, Inc. "UHS" for management and UHS or UnitedHealthcare, Inc. for ownership), or (ii) offers the PPO or other products (that is United HealthCare Insurance Company).
- (2) d/b/a: UHC of Ohio; also licensed in Kentucky.
- (3) 50% is held by American International Group, Inc.
- (4) Limited or single service health Plan
- (5) This entity will dissolve or merge with another UHG legal entity.
- (6) Ingenix, Inc. owns .01%. Established a representative office in Beijing, China.
- (7) Also doing business as United HealthCare of Indiana, Inc. (IN); also licensed in Indiana.
- (8) Licensed in Iowa and Nebraska.
- (9) Licensed in Rhode Island and Massachusetts.
- (10) 50% owned by Richard Saul Wurman.
- (11) Licensed in Missouri, Illinois and Kansas.
- (12) 10% is held by UHC International Holdings, Inc.
- (13) **United HealthCare Services, Inc. ("UHS")** (formerly UHC Management Company, Inc. and before that Charter Med, Inc.) is a Minnesota corporation and wholly owned subsidiary of UnitedHealth Group. It is the technical employing entity (i.e., it files the payroll taxes in the 50 states) for substantially all UnitedHealth Group employees. It is qualified to do business in all 50 states, the District of Columbia and Puerto Rico. It is not licensed as an HMO or an insurance company but is licensed in several states as a PPO, TPA or UR agent. It is the management company for almost all the health plans and the insurance companies. It owns most of the assets (i.e., desks, computers etc.) used by all employees. It rents most of the space used by all UnitedHealth Group entities and people. Many of the specialty businesses, i.e., Evercare, URN, Optum, Healthmarc, are divisions of UHS, though URN and Optum are becoming their own companies. This is the entity that should be the party to the facilities, supply or other contracts that are for UnitedHealth Group generally. See p. 4 for UHS' assumed names.
- (14) Licensed as a PPO or MCO in one or more states.
- (15) Licensed as a UR Agent in one or more states.
- (16) Licensed as a TPA in one or more states.
- (17) Subsidiary being formed in Croatia.
- (18) Licensed as a health care services contractor, but in process of withdrawing.
- (19) Intentionally left blank.
- (20) Other 50% is owned by UnitedHealthcare Asia Limited currently, but UnitedHealthcare International Asia, LLC will own 99% and UnitedHealthcare Asia Limited will own 1% after additional shares are issued.
- (21) Also licensed in Virginia and the District of Columbia. United HealthCare of Virginia, Inc. merged into it effective 12/31/01 on approval of VA BOI, MIA, & MD DAT (later filing by VA Corp).
- (22) 19.9% owned by ACN 3, LLC (name change pending).
- (23) d/b/a: DICA, Inc. in Texas

- (24) General partnership interest held by UHS and Commonwealth Physician Services Corporation. UHS also holds 99.4% of the limited partnership interests. Doing business as **United HealthCare of Kentucky, L.P.** in Indiana. Licensed as an HMO in Kentucky and Indiana.
- (25) A Hong Kong "private" limited liability company owned 99% by **UnitedHealthcare International Asia, LLC** and 1% by **UnitedHealthcare International, Inc.**
- (26) d/b/a: **UnitedHealthcare, Inc.**, a Corporation of Delaware (obtained for use in Oklahoma).
- (27) A Hong Kong limited liability company. Also qualified in Malaysia.
- (28) Intentionally left blank
- (29) UHG is the sole member of the **UnitedHealth Foundation** and the **Foundation for Health Care Policy and Evaluation** both MN non-profit organizations.
- (30) **United HealthCare Insurance Company** is a Connecticut domestic health insurance company that is licensed as an insurance company in 49 states (not New York), District of Columbia, Puerto Rico, Guam and the Virgin Islands. This entity owns significant assets (such as desks, computers, etc.) and offers a variety of products including EPO, PPO, ASO/self-funded and indemnity.
- (31) Licensed in Ohio only.
- (32) Licensed in New York and the District of Columbia.
- (33) Licensed in Illinois and Florida only.
- (34) **PhilamCare Health Systems, Inc.** is 49.86% owned by **PhilamLife** and .28% owned by various individuals.
- (35) 20% of **Dental Benefit Providers, Inc.** is owned by **Irongate, L.L.C.**, a Delaware limited liability company.
- (36) Not yet licensed.
- (37) Branches in Republic of South Africa, the Netherlands, Sweden, and Germany. Withdrew from Hungary Jan. 2, 2001.
- (38) Assumed names for **UnitedHealth Networks, Inc.** which must be used in the states listed below:  
 - UHN **UnitedHealth Networks** (obtained for use in New Hampshire)  
 - UHN **UnitedHealth Networks, Inc.** (obtained for use in Texas)  
 - **United Networks** (obtained for use in New York)  
 - **UnitedHealth Network, Inc.**, a Corporation of Delaware (obtained for use in Ohio)  
 - **UnitedHealth Networks, Inc.**, a Corporation of Delaware (obtained for use in Oregon)  
 - **Ingenix International (UK) Limited** owns 1%.
- (39) **Ingenix International (UK) Limited** owns 1%.
- (40) **Manages California Clinical Trials Medical Group.**
- (41) **British Medical Journal** owns 50%.
- (42) One percent owned by **Lifemark Corporation.**
- (43) One percent owned by **ClinPharm International Ltd.**

United HealthCare Services, Inc.'s filed assumed names/dbas include (continuation of footnote 13):

- Center for Health Care Policy and Evaluation (MN)
- Charter HealthCare, Inc. (NM, RI)
- Employee Performance Design (IL, KY, MN, NE, OR)
- EverCare (AZ, CA, CO, FL, GA, IL, IN, MD, MA, MI, MN, OH)
- GenCare PPO (IL, MO)
- Health Professionals Review (ME)
- HealthCare Evaluation Services (MN)
- Healthmarc (AZ, CA, GA, IN, IA, KY, ME, MD, MI, MN, MO, NV, NH, NJ, NC, RI, TN, TX, UT, VA)
- Healthmarc, Inc. (WV)
- HealthPro (AK, CT, IL, KY, MA, OH, VT)
- Institute for Human Resources (FL, OR, WA)
- Managed Care for the Aged (MN)
- Optum (MN, CA)
- Personal Decision Services (MN)
- UHC Management & Administrators (CA)
- UHC Management (VT)
- UHC Management Company (AK, MA, NH, UT, WV)
- UHC Management Company, Inc. (AL, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NJ, ND, OH, OR, PA, RI, SD, TN, TX, VA, WA)
- UHC of Illinois Inc. (IL)
- UHC of Missouri and United HealthCare of Missouri (MO)
- UMC Management Company, Inc. (OH)
- United HealthCare (MA, UT)
- United HealthCare Corporation (AZ, AR, CA, CO, CT, DE, FL, GA, ID, IN, IA, KY, LA, ME, MD, MO, MT, NC, ND, NE, NJ, OH, OR, RI, SD, TX, WA)
- United HealthCare Management (VT)
- United HealthCare Management Company, Inc. (IL, MI, OK, PA, TN, VA)
- United HealthCare Management Services (PA, NY)
- United HealthCare of Illinois, Inc. (IL)
- United HealthCare Services of Minnesota (NH)
- United HealthCare Services of Minnesota, Inc. (AR, FL, IL, OK, RI, SD, VT, WV)
- United Resource Networks (CA, GA, IL, IN, IA, MD, MI, MN, MO, NE, NY, NC, RI, UT)
- United Resource Networks, Inc. (CO, TN)
- UnitedHealth Group Incorporated (CA)

### *Transactions and Agreements with Affiliates*

It was determined by the examiners that the terms and conditions of related party agreements are not reviewed for fairness and reasonableness by anyone at the Company. The review of these agreements is done by senior management at United HealthCare Services.

#### Lack of Agreement

The examiners first requested information on the make up of Net transfers to affiliates, page 6, column 1, line 13.2 of the 2001 Annual Statement on May 28, 2003. According to an email from the Company, its affiliate Ingenix, Inc. "has a division (formerly Subrogation Advantage) that assists in the recovery of third party liability health care expenses. When a recovery is made Ingenix will retain a portion of the recovery as part of their fee for negotiating payment from the third party and will then send the remaining amount to the health plan that had incurred the original cost of the claim. The Ingenix fee is a percentage of the recovery amount. The receivable, at December 31, 2001, represents reimbursements or refunds to the health plan for a recovery amount that had been received through the efforts of Ingenix Subrogation." Company employees at both Ingenix and United HealthCare of Alabama stated that neither United HealthCare Services, Inc. nor United Healthcare of Alabama, Inc. has an agreement with Ingenix, Inc.

#### Management Agreement

During the examination period ending December 31, 2001, the Company had no employees. It operated under an amended and restated *Management Agreement*, which was as of December 31, 1999, with United HealthCare Services, Inc. (UHS), Minnetonka, Minnesota. The agreement stipulated that the Company shall engage in the business of arranging for the provision of health care coverage to its enrollees, and UHS shall provide to the Company certain administrative, financial and managerial services necessary for its day-to-day operations. These included, but were not limited to the following:

- computerized management information systems;
- development and implementation of standardized contracts concerning the Company's subscribers and providers;
- preparation and filing of required applications and records;

- general administrative and financial services;
- placement and maintenance of insurance with respect to Company operations;
- underwriting services;
- internal audit services;
- marketing, sales, and provider relations;
- recruitment, compensation and supervision of all on-site personnel;
- retention of adequate office space, furniture and equipment;
- maintenance of appropriate books and records with respect to its activities, whereby all documentation is available for review by Company representatives and the Alabama Insurance Department; and
- the establishment of a payment process.

The Company was responsible for the costs associated with the following:

- payment of all debts and obligations of the Company;
- retention and compensation of independent auditors;
- payment of all fees and costs directly and indirectly related to the delivery of health care services and supplies to enrollees;
- establishment and maintenance of appropriate financial reserves, capital requirements and payments relating to deposits, annual fees and licensing fees;
- payments relating to premium, income, sales, or any other form of taxes;
- payments made to any independent broker, consultant or agent in regard to sales of the Company's products or programs or to other independent consultant or advisors;
- premiums for policies of insurance with the respect to the Company's operations;
- bad debt expenses; and
- activities and expenses related to the Board of Directors and Committees of the Company.

The monthly management fee for these services was calculated at a specific dollar amount multiplied by the number of persons covered by the Company's commercial managed care programs for that month, including individuals and their dependents whose employers or groups offer a self-funded health care coverage program, which utilizes the Company's provider network.

Another required monthly management fee was calculated by multiplying a specific dollar amount by the number of persons covered by the Company's Medicare managed care programs for that month.

Both of these monthly management fees were to be paid on or before the 10<sup>th</sup> calendar day of each month. The final calculation for the management fee for the calendar year shall be calculated within fifteen calendar days of receipt of the Company's audited financial statements. Any additional amounts required by such calculation or repayments by United HealthCare Services, Inc. to the Company of previously credited fees shall be made within thirty calendar days following receipt of the audited financial statements.

Termination of this agreement requires prior notification to the Alabama Insurance Commissioner.

Three prior examination reports, as of December 31, 1992, December 31, 1996, and December 31, 1999, recommended that the Company obtain approval of its management agreement from the Alabama Insurance Commissioner in accordance with ALA. CODE § 27-21A-4 (1975) and Section 13 of Alabama Department of Insurance Regulation Number 79.

The Company provided a letter, dated September 4, 2001, from the Alabama Department of Insurance, stating that the Company's "Amended and Restated Management Agreement by and between United HealthCare of Alabama, Inc. and United HealthCare Services, Inc." had been approved by the Commissioner.

#### Premium Allocation Agreement

United HealthCare Services, Inc. (UHS) on behalf of itself and as operator of those of its affiliated health maintenance organizations entered into a Premium Allocation Agreement, made effective as of January 1, 1998, with United HealthCare Insurance Company (UHI). The agreement included, but was not limited to, the following provision:

“UHI shall be entitled to receive consideration received for insurance coverage marketed and issued in conjunction with products marketed and issued by the HMOs which shall be (i) fair and reasonable; (ii) determined according to actuarial review conducted at least annually; (iii) allocated in conformity with customary insurance accounting practices consistently applied.”

The Premium Allocation Agreement was not approved by the Alabama Department of Insurance. This agreement violates of ALA. CODE § 27-21A-6(c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's name..." ALA. CODE § 27-41-2 (5) (1975) defines an investment as any asset owned by an insurer. ALA. CODE § 27-41-2 (6) (1975) defines an eligible investment as any investment permitted by ALA. CODE § 27-41-7 to 27-41-35, (1975) inclusive, provided the investment meets all the other requirements of this chapter. Finally, ALA. CODE § 27-27-29 (1975) requires that "Every domestic insurer shall have, and maintain, its assets in this state..."

#### Tax Sharing Agreement

On November 15, 1995, the Company entered into a Tax Sharing Agreement, made effective as of January 1, 1990, with its ultimate parent, UnitedHealth Group Incorporated, formerly United HealthCare Corporation (UHC) and other affiliated companies in the UHC group. The agreement applied to tax returns beginning with the year ended December 31, 1990, and for each subsequent taxable year. The agreement included, but was not limited to, the following provisions:

- Each member shall pay UHC an amount equal to the full separate federal, state and local (if any) income tax liability attributable to the net taxable income of such member that would have been paid if such member had filed separate federal, state and local income tax returns.
- Any federal surtax exemption available to the group shall be allocated proportionately to UHC and the members based upon the taxable income for such tax year produced. In the event any member has a loss, for the purpose of allocating the surtax exemption for such tax year, such member shall be deemed to have no federal taxable income.

This agreement was not approved by the Alabama Department of Insurance, as required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states that: "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care

activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer..."

#### Subordinated Revolving Credit Agreement

The Company ("Borrower") entered into a subordinated revolving credit agreement with UnitedHealth Group Incorporated, formerly United HealthCare Corporation ("Lender"), effective December 1, 1999. The agreement included, but was not limited to, the following provisions:

- Lender agrees to lend and re-lend amounts requested by the Borrower, not to exceed the aggregate principal amount, if any, set forth in Borrower's Addendum to be outstanding at any one time.
- Lender may require that each loan hereunder be evidenced by a note.
- Interest on the outstanding balance of each loan shall be payable at the one month London InterBank Offered Rate in effect on the last business day of the calendar month prior to the calendar month for which interest is being calculated plus fifty basis points.

The agreement was used once in the fourth quarter of 2001. The Company borrowed five million dollars in October 2001 and paid it back in November 2001.

The Company provided copies of letters, dated November 9, 1999 and October 28, 1999, sent to Mr. John MacBain at the Alabama Department of Insurance requesting approval of this agreement. According to the Company, they have not received any correspondence from the Department concerning this agreement.

Mr. MacBain is one of the Alabama Department of Insurance's consulting actuaries and is not in a position to approve or disapprove intercompany agreements for the Department of Insurance. This agreement was not approved by the Alabama Department of Insurance, which is required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states that: "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer..."

### Agreement for the Provision of Services

This agreement, effective January 1, 1996, was between United Behavioral Health, Inc. (UBH) and the Company. This agreement sets forth the terms and conditions under which UBH provided and/or arranged for the provision of certain mental health and substance abuse services to individuals covered by benefits plans sponsored or issued by the Company.

The agreement was an exclusive agreement regarding the rights, responsibilities, and other conditions for the provision and payment of Mental Health and/or Substance Abuse (MHSA) Services and/or Utilization Management (UM) Services. The responsibilities of UBH shall be limited as defined by the terms of this agreement.

- UBH is responsible for arranging for a Provider network to provide mental services to covered persons.
- UBH shall assure that 90% of all covered persons who reside within the service area are within 30 miles or 30 minutes of a Provider.
- UBH shall provide to all covered persons a 24-hour toll-free telephone line, for referral for required services, crisis intervention, and responding to inquiries regarding available services.

This agreement may be terminated:

- by either party, with sixty days written notice in the event of a material breach by the other party of any term of the agreement.
- by either party, at any time for a "without cause" termination upon 120 days written notice.

Fees related to this agreement were approximately \$4,405,000 in 2001, and were included in medical services expenses.

### Transplant Services Agreement

The Company had a transplant services agreement with United HealthCare Service, Inc. (UHS), Minnetonka, Minnesota, on behalf of its division, United Resource Networks (URN), signed November 19, 1999. According to this agreement, UHS shall provide certain services to the Company, including the following:

- arrangements for access to participating providers for the provision of certain transplant services as described in the Network Access Appendix;
- payment for services in accordance with terms as stipulated in the Appendix;
- statement of conduct in reference to discriminating or differentiating in the rendering of transplant services to members;
- assistance in obtaining cooperation from participating providers concerning utilization management and quality assessment programs;
- maintenance of all federal, state, and local licenses, certifications and permits necessary for the provision of transplant services for all Healthcare professionals employed by or under contract to the provider;
- verification that each party may audit and/or copy pertinent files and records directly related to the agreement;
- each party deemed responsible for claims, liabilities, damages, or judgments that may arise as a result of negligence or intentional wrongdoing; and
- payment of monthly fee for each member enrolled or covered by plans sponsored or issued, as of the first day of each month. The fee for this service was increased effective January 1, 2001 and again in 2003.

This agreement may be terminated by either party, upon thirty days prior written notice to the other party, in the event of a material breach of the agreement, or in the event that the other party is no longer an affiliate of United HealthCare Group. Either party may also terminate upon ninety days prior written notice to the other party, which may be given at any time after the agreement has been in effect for three years.

The Company provided letters, dated July 10, 2001 and September 4, 2001 from the Alabama Department of Insurance, stating that the Company's "Amendment to the United HealthCare Services, Inc. Transplant Services Agreement" had been approved by the Commissioner.

Fees related to this agreement were approximately \$76,000 in 2001, and were included in medical services expenses.

#### OPTUM Services Agreement

The Company had an agreement, effective November 1, 1999, with OPTUM, a division of United HealthCare Services, Inc. (UHS), to provide a 24-hour call-

in service, called *Care24*, to its enrollees. Services included in various addenda were as follows:

Care24; and  
Health and Well Being Information

Administrative services included the following:

- standard aggregate reports within 45 days after the end of the reporting period;
- communications materials and activities;
- responsibility for damages and insurance;
- regulatory compliance and filing;
- maintenance of books and records.

Other services were available upon mutual agreement of the parties.

The agreement can be terminated after the initial term (ending December 31, 2000), with ninety days written notice, and will automatically renew for additional one-year terms.

Fees related to this agreement were approximately \$1,163,000 in 2001, and were included in medical services expenses.

The first Restated Participating Plan Addendum of this agreement was approved by the Alabama Department of Insurance per a letter from the Alabama Department of Insurance dated September 4, 2001.

#### Diversified Pharmaceutical Services Agreement

The Company had an agreement with United HealthCare Services, Inc. (UHS), to provide administrative services related to pharmacy management and claims processing for its enrollees. UHS contracts with Diversified Pharmaceutical Service, Inc. (DPS) for the provision of these services. It operated under the service agreement, which was amended and restated as of January 1, 1998. DPS provided certain services, which included:

- prescription drug benefit management services to health maintenance organizations, health insurance companies and other health plans and health plan administrators owned or controlled by UHS;
- sufficient personnel and resources to successfully administer UHS and companies' pharmacy programs and provide the services contemplated by this agreement;
- monthly reports to UHS regarding the personnel;
- claims processing services related to claims for prescriptions dispensed on or after the "Claims Processing Commencement Date" for each company;
- timely notice on a periodic basis to UHS, via standard reports or otherwise, of the amount of companies' liability for claims processed;
- establishment of a pharmacy network strategy consistent with the overall strategy for UHS' health plan and health insurance business;
- provision of clinically-based utilization and cost management programs- and services relating to Prescription Drug services, including DUE (Drug Utilization Evaluation) and DUR (Drug Utilization Report) programs, formulary transition programs, generic drug utilization programs and other related education initiatives and communications to participants or participating providers;
- the use of the drug formularies approved by DPS's National Pharmacy and Therapeutics Committee, or one or more drug formularies adopted by UHS based on a DPS template formulary;
- participation in the rebate program with respect to all benefit plans underwritten, issued or administered by such companies;
- responsibility for responding to inquiries from participation pharmacies regarding the services provided by DPS; and
- prescription alert services made available via on-line communication (known as the Diversified AlertCare service) to participating pharmacies.

Fees related to this agreement were approximately \$714,000 in 1999, and were included in operating expenses. Pharmacy rebates on certain pharmaceutical products were based on member utilization. Rebates amounted to approximately \$2,538,000 in 1999, and were included as a reduction to medical services expenses.

It was noted that the agreement with DPS was terminated on May 31, 2000.

## Vision Care Services Agreement

United HealthCare Service, Inc. (UHS), Minnetonka, Minnesota, on behalf of health plans that are owned and/or managed by UHS and its affiliates had a vision care services agreement with Coordinated Vision Care, Inc. ("CVC"), a vision benefit management company. According to this agreement, CVC shall provide certain services to UHS, including the following:

- manage and arrange for participating providers to provide vision care services to members;
- establish and maintain a credentialing process to which all participating providers shall be subject;
- provide participating providers with an inventory of frames to display in their offices;
- establish and maintain contractual relationships with wholesale laboratories for the fabrication of prescription ophthalmic lenses.
- make initial determinations on whether services and/or supplies requested by or on behalf of a member or for which a member has requested reimbursement are vision care services;
- process claims for vision care services;
- attempt to resolve any disputes that arise regarding coverage;
- provide consulting services which relate to vision benefit designs, underwriting considerations and marketing strategies;
- provide UHS with monthly or quarterly reporting, accrediting agency reporting, and specialized reporting regarding the vision care services managed and arranged by CVC; and
- establish and maintain a quality management program, provider credentialing and re-credentialing program, and other programs.

UHS is responsible for the costs associated with the following:

- provide CVC with a current list of participating plans' members at least thirty days before the effective date, and at least weekly thereafter;
- any claims for vision care services related to retroactive adjustments of eligibility greater than sixty days; and
- regulatory compliance associated with the vision benefits set forth in the benefit contract(s) and for filing the agreement with federal, state and local governmental authorities as required by any applicable law or regulation.

An addendum to this agreement was entered into between United HealthCare of Alabama, Inc. ("Company") and Coordinated Vision Care, Inc. ("CVC") effective October 1, 2001. In addition to the responsibilities outlined in the agreement, CVC and the Company agree to assume the following responsibilities:

- CVC agrees that it shall maintain at its principal office books and records that are usual and customary for the services provided under this agreement for the duration of the agreement and at least five years thereafter.
- The Company acknowledges that it retains the ultimate responsibility to assure delivery of all vision care services required by the benefit contract.
- CVC shall provide a copy of its provider manual to all providers at the time they are reviewing/evaluating CVC's Provider Participation Agreement for participation in CVC's provider network.
- CVC will provide information regarding payment and incentive arrangements to all providers at the time they are reviewing/evaluating CVC's Provider Participation Agreement for participation in CVC's provider network.
- The Company shall provide CVC with a copy of its provider manual, and will provide CVC with written notice of any changes to the provider manual.
- The Company will pay CVC a per member per month fee for each member as set forth in the applicable rate appendix, as compensation for CVC's network and management services.

The addendum between United HealthCare of Alabama, Inc. ("The Company") and Coordinated Vision Care, Inc. ("CVC") effective October 1, 2001 was approved by the Alabama Department of Insurance per a letter from the Department of Insurance dated September 4, 2001.

Fees related to this agreement were approximately \$21,000 in 2001, and were included in medical services expenses.

### *Dividends to Stockholder*

The Company paid dividends of \$5,748,508 in 2001 to its sole shareholder.

## **FIDELITY BOND AND OTHER INSURANCE**

The Company was a named insured on a financial institution bond issued by National Union Fire Insurance Company of Pittsburgh, Pennsylvania, which met the minimum requirement of the NAIC Financial Examiners Handbook. This bond covered the following: employee dishonesty, loss inside the premises, loss outside the premises, money orders and counterfeit paper currency, and depositors forgery coverage.

In addition to the aforementioned fidelity bond, the Company also maintained the following coverage to protect the Company against hazards to which it may be exposed:

- Auto Coverage
- Directors, Officers and Corporate Liability Insurance
- Commercial General Liability
- Commercial Catastrophe Liability
- Managed Care Professional Liability
- Blanket Crime Policy
- Real Property including Building and Personal Property
- Workers Compensation and Employee Liability

The coverage and limits carried by the Company were reviewed during the course of the examination and appeared to adequately protect the Company's interests at the examination date. The records of these insurance policies were being kept in Minnetonka, Minnesota. The Company was not in compliance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

## **EMPLOYEE AND AGENTS WELFARE**

It was determined that the Company has no retirement plan, deferred compensation and/or other benefit plans, since all personnel are employees of United Healthcare Services, Inc., which provides services to the Company under the terms of a management agreement.

## **SPECIAL DEPOSITS**

The State of Alabama held, as a statutory deposit, a \$100,000 par value, 7.5% interest rate, U.S. Treasury Note, with a maturity date of May, 15, 2002. At December 31, 2001, this bond had a statement value of \$100,368 and a fair value of \$102,156.

## **FINANCIAL CONDITION/GROWTH OF THE COMPANY**

The following table shows assets, liabilities, capital and surplus, and net premium income for 1999-2001, as disclosed in the Company's filed Annual Statements.

|                           | <b><u>1999</u></b> | <b><u>2000</u></b> | <b><u>2001</u></b> |
|---------------------------|--------------------|--------------------|--------------------|
| Net Admitted Assets       | \$ 93,561,946      | \$115,715,641      | \$133,380,386      |
| Total Liabilities         | \$ 80,093,919      | \$ 85,519,636      | \$ 74,444,955      |
| Total Capital and Surplus | \$ 13,468,027      | \$ 30,196,005      | \$ 58,935,431      |
| Net Premium Income        | \$386,697,170      | \$405,033,189      | \$394,789,266      |

## **MARKET CONDUCT ACTIVITIES**

For most aspects of consumer relations, the Company is regulated by the Alabama Department of Public Health (ADPH). During the examination period, ADPH conducted several audits throughout the period under examination. The ADPH conducted a comprehensive audit, dated August 14-18, 2000.

The Alabama Department of Public Health conducted a claims audit on United HealthCare of Alabama, Inc. on July 29-August 2, 2002. The audit resulted in finding that United HealthCare of Alabama, Inc. was out of compliance with both the Alabama Prompt Pay Law and Public Health Rule 420-5-6.06(13)(a).

On May 29, 2003, the Alabama Department of Public Health deemed the Company's plan of correction for the 2002 annual claims audit acceptable.

On July 14-18, 2003, ADPH conducted an audit on the Company's operations: Organization and Quality Assurance/Utilization Review.

### ***Territory***

As of December 31, 2001, the Company was licensed to transact business in the state of Alabama only. The certificate of authority was inspected and found to be in order.

The Alabama Department of Insurance and the Alabama Department of Public Health authorized the Company to market business in the following Alabama Service areas or counties at the examination date.

|          |           |            |            |
|----------|-----------|------------|------------|
| Autauga  | Colbert   | Hale       | Mobile     |
| Baldwin  | Conecuh   | Houston    | Monroe     |
| Barbour  | Coosa     | Jackson    | Perry      |
| Bibb     | Covington | Lauderdale | Pickens    |
| Blount   | Crenshaw  | Jefferson  | Pike       |
| Bullock  | Cullman   | Lawrence   | Shelby     |
| Butler   | Dale      | Lee        | St. Clair  |
| Calhoun  | Dallas    | Limestone  | Talladega  |
| Cherokee | Dekalb    | Lowndes    | Tallapoosa |
| Chilton  | Elmore    | Macon      | Tuscaloosa |
| Choctaw  | Escambia  | Madison    | Washington |
| Clarke   | Etowah    | Marshall   | Wilcox     |
| Cleburne | Franklin  | Montgomery | Walker     |
| Coffee   | Greene    | Morgan     |            |

The Company failed to report the addition of Butler, Cherokee, Dekalb and Pike counties as new territories for operation in its 2001 Annual Statement.

### ***Plan of Operation***

The Company, a for-profit health maintenance organization (HMO), offered its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. These included fully insured and self-funded point-of-service (POS) and HMO products. The HMO products

included a closed access network that emphasized the role of the primary care physician and an open access plan. The POS, or "plus" products featured closed access and open access models with out-of-network benefits. The Company also offered a Medicare risk HMO product called "Medicare Complete" to its senior members.

Lines of business, as reported in the 2001 Annual Statement included:

- Comprehensive (hospital and medical)
- Medicare Supplement
- Title XVIII - Medicare

In order to provide the most comprehensive health care to its members, the Company relied on a variety of delivery systems. Those delivery systems were designed to meet the customers' needs for preventive care and comprehensive health care. The total delivery system included: -

- Hospitals
- Skilled nursing facilities
- Rehabilitation facilities
- Home health care
- Mental Health/Substance Abuse
- Pharmacy services
- Other ancillary services
- Primary care physicians
- Specialty physicians

### ***Provider Contracts***

Provider contracts and turnover rate matters are mostly reviewed by the Alabama Department of Public Health. The examiners' review of the number of provider additions and deletions in the years 2001 and 2002 revealed that the Company had a large number of provider terminations in the first quarter of 2001. Most of the provider terminations were due to the Company refusing to renew contracts of providers that refused to sign all payor agreements or those providers that did not see a lot of enrollees. In addition, Company management indicated that 1.) there was a higher than usual amounts of provider retirements and relocations and 2.) the Company lost a large number

of anesthesiologists in the Mobile area. The Company is allowed to use these practices, which were known by the ADPH and no further explanation was required from the Company.

### *Policy Forms and Underwriting Practices*

The United HealthCare of Alabama, Inc. Underwriting Department was responsible for the development and implementation of underwriting and pricing policies. The underwriting manual outlined the different products available and the sales process for the different group sizes and products.

The Company bases underwriting for a plan on various factors including the following:

- Any significant changes in enrollment in the plan
- The turnover rate of enrolled subscribers
- The age of each employee, or alternatively, aggregate age information categories of not more than five-year increments
- The gender of each employee. This may be compiled as aggregate information by category.
- The number of dependents, if available.
- Whether the employee is eligible for "single" or "family" coverage, and if three-tier, the number of "dual coverage."
- Whether the employee elects "single" or "family" coverage, and if three-tier, the number of "dual coverage."

New plan designs, benefits, etc., during the examination period were added to rate cards, and changes were filed with the Life and Health Division of the Alabama Department of Insurance.

The examiners selected a sample of 132 reinstated policies during the examination period. The Company initially did not provide eleven or 9% of the requested files. These records should be kept and organized for examination purposes as required by Alabama Department of Insurance Regulation Number 79 Section 15, which requires that:

"... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions and affairs..."

The Company subsequently provided the missing reinstated policy files. However, these files were not provided within the ten days required by Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

### ***Advertising and Marketing***

The sale and advertising material provided by the Company was maintained in accordance with Section 6 of Alabama Department of Insurance Regulation Number 79.

The Company filed the certificate of compliance with the annual statement in accordance with the aforementioned Regulation.

The examiners noted two problems during the review of the Company's files.

- 1.) The Company's renewal notices sent to its customers during 2001 and 2002 are ambiguous and misleading. The letterhead is listed as "UnitedHealthcare" on the first line, followed by "A UnitedHealth Group Company" on the second line with "United Healthcare of Alabama, Inc." on the third line. The examiners could not locate any companies with the names of "UnitedHealthcare" or "A UnitedHealthGroup Company" on the company's organizational chart. In addition, the renewal notice states, "You asked for it, you got it! UnitedHealthcare is proud to offer you and your employees Life/AD&D coverage." This is misleading because to the examiners' knowledge there is no such company as "UnitedHealthcare." In

addition, United Healthcare of Alabama, Inc. is not licensed to sell life or AD&D coverage. The Employer Application does list prominently that the application is to be provided to United HealthCare and in a sub-heading below it states "Insurance Products provided by United Health and Life Insurance Company." The examiners did not find "United Health and Life Insurance Company" listed on the Company's organizational chart.

- 2.) The Company's "Urgent Reinstatement Fax" documents list on the first line "UnitedHealthcare" and on the second line "A UnitedHealth Group Company." Nowhere on the fax is United HealthCare of Alabama listed. In addition, the fax instructs the customer to "Mail Certified Funds, Automatic Withdrawal Form, and Voided Bank Check" to United Healthcare in Lake Mary, Florida. In addition to the company names being ambiguous and misleading, the Company was directing the customer to send its premiums to an entity located outside the state of Alabama. ALA. CODE § 27-21A-6 (c) (1975) requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..." ALA. CODE § 27-27-29 (1975) requires that "Every domestic insurer shall have, and maintain, its assets in this state..."

ALA. CODE § 27-21A-13 (3) (d) (1975) requires that: "No health maintenance organization unless licensed as an insurer may refer to itself as a licensed insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in this state."

Alabama Department of Insurance Regulation Number 79 Section 12 requires that "No name other than that approved by the Commissioner may be used. The name of the HMO may not be changed without prior approval of the Commissioner. Any name which is misleading as to the purpose or type of organization or which is deceptively similar to the name of another licensed HMO shall not be used by the HMO."

Alabama Department of Insurance Regulation Number 79 Section 6 states that "Advertising includes printed and published material, descriptive literature and sales aids, sales talks and sales materials, booklets, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television or direct mail advertising..."

Alabama Department of Insurance Regulation Number 79 Section 6 requires that "...Advertising must be truthful and not misleading in fact or implication. Words or phrases shall not be used whose meaning is unclear, ambiguous..." "...Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity or tendency to deceive or mislead." "...All advertisements must contain the name and address of the HMO as filed with the Commissioner."

ALA. CODE § 8-19-5, (1975) states that "The following deceptive acts or practices in the conduct of any trade or commerce are hereby declared to be unlawful:...(2) Causing confusion or misunderstanding as to the source, sponsorship, approval, or certification of goods or services..." "(27) Engaging in any other unconscionable, false, misleading, or deceptive act or practice in the conduct of trade or commerce."

### ***Claims Payment Practices***

The examiners reviewed a sample of 132 claims files on paid and denied claims. These were used for the study of the turnaround times on claims and were selected using the listings of claims paid in 2000 and 2001 through both UNET and COSMOS claim payment systems. The examiners were able to verify dates of receipt and payment or response on all of the claims. Timeliness of response by either payment of the claim or notification of nonpayment to the claimant was studied. Adequacy of documentation was also reviewed. It was determined that the Company responded within the 30 days required for electronic claims and the 45 days required for clean paper claims. However, see "Alabama Department of Public Health Claim Review" -- page 36 for related discussion.

### **Location of Claim Files**

The Company's claim files were kept in Minnesota. These records should be kept in a location approved by the Commissioner as required by ALA. CODE § 27-21A-16 (f) (1975)

### Alabama Department of Public Health Claim Review

On October 4, 2002, the Commissioner received a copy of the report on the Company's claims handling practices issued by the Alabama Department of Public Health (ADPH). The report pointed to following matters:

- The Company did not provide an aged claim status report of all unpaid ER claims. The Company states that there is an inability to track and report the aging status of emergency claims as a separate category of claims.
- The Company states an inability to track and report the aging status of paper claims by provider and pend reason separate from an overall inventory report of aging electronic and paper claims.
- All reports, interviews, policies and audits of sampled claims indicated that the Company is not tracking resubmitted claims for the 21 day resubmission processing requirement in the Alabama Prompt Pay law. - Upon receipt of a resubmitted claim, the claim is assigned a new number and processed as a new claim. While processors have access to previous claim information, the Company is not tracking for the 21 day resubmission deadline.
- All reports, interviews, and policies indicated that providers are not receiving written notification if a claim is pended "internally" and not denied or paid within the required 45, 30 or 21 days.
- The Company assigns a new claim number to a claim regardless of how many times a claim may be resubmitted. This means that a paper claim may have been submitted a number of times before being determined to be "clean." Therefore, aging reports are suspect. In addition to assigning new claim numbers to resubmitted claims, the Company does not track re-submissions per the Alabama Prompt Pay Law.
- The Company does not have a policy that sets a maximum time limit for the pending of a claim before it is either denied or paid.

On May 29, 2003, the Company provided ADPH an acceptable plan of correction, which is currently being implemented and is monitored by the Alabama Department of Public Health.

### Claim Checks Issuance

When reviewing a sample of paid claims, the examiners determined that the checks the Company issued for payments of claims were cashed (or deposited) within the following number of days.

| Number of Checks Cashed | Days until presentation to Bank |
|-------------------------|---------------------------------|
| 1                       | 2                               |
| 4                       | 3                               |
| 11                      | 4                               |
| 17                      | 5                               |
| 19                      | 6                               |
| 16                      | 6                               |
| 8                       | 8                               |
| 6                       | 9                               |
| 7                       | 10                              |
| 1                       | 12                              |
| 1                       | 13                              |
| 1                       | 15                              |
| 1                       | 23                              |

The average number of days for a claim check to be cashed (or deposited) was 6.67 days. In reviewing one of the litigation files, the examiners found an internal letter instructing one of the Company employees to hold a claim check for 48 hours before mailing. The letter was dated June 18, 2002 and was from a compliance assistant to another employee at the Company: "Attached is payment verification on the claim of Dr. Routman in the above matter. The check should be written and mailed sometime tomorrow (48 hours after "paid" date)."

### Mental Health Benefits

The examiners determined from reviewing the Company's schedule of benefits that the Company imposed a limit on the number of outpatient mental health and substance abuse services visits. The Company's benefits offered were limited to 52 mental health visits per calendar year and did not have the same limit on medical and surgical services. This was not in compliance with ALA. CODE § 27-54-4 (b) (1) (1975), which stipulates that:

"The group health benefit plan shall offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses."

#### Pharmacy Claims

The examiners selected a sample of 132 claims from the paid claims detail supplied by the Company. The examiners then requested the claim files to verify the dates the claims were received and paid and to perform various other tests on the canceled claims checks.

The Company was unable to provide the examiners with 39 of the paid claims files that were sampled. These 39 claims were pharmacy claims. The Company explained that the checks are written by Medco, the company that processes the pharmacy claims for the Company, and because of this the Company does not have access to the canceled checks. The Company should have a database or the ability to query a database by policyholder and/or claim amount that ties back into specific "batch" payments, which ultimately tie back into a canceled check or wire transfer.

The Company's explanation for this is that United Healthcare Services "UHS" contracts with Medco to pay all of the pharmacy claims for the health care plans under UHS. Medco is then responsible for paying the pharmacy claims for UHS and many other different health care providers in large pools of claims to the individual pharmacies. The Company reimburses UHS for the pharmacy claims through the Intercompany Settlement System. Company management responded that: "Given the amount of time it will take to pull the requested documentation to indicate how the pharmacy claim payments tie to the UnitedHealthcare general ledger, we will not be providing the sample items requested by Anne Ogle and Shaun Sori."

This failure to provide information necessary for the exam is a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

### ***Treatment of Members and Claimants***

During the review of the Company's complaint handling procedures, the examiners did not find any guidelines requiring Company personnel to respond to complaints received through the Alabama Department of Insurance within ten days. Alabama Department of Insurance Regulation Number 118, Section 6, requires that:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

and Alabama Department of Insurance Bulletin dated January 31, 1963, states:

"The Department of Insurance henceforth will take the position that an insurance company must answer both the policy holder and this Department within ten days after receipt of a departmental complaint."

### ***Policyholder Complaints***

The Company maintained consumer complaint files that were received either directly from the customer or through the State's Department of Public Health or Department of Insurance Consumer Division. These files were maintained by year and insured name.

The Company's pre-established complaint handling procedures provided for prompt and proper handling of the complaints. Guidelines were included for the handling of every type of complaint. The operation manager was responsible for monitoring trends in complaints.

During the examination period, the Company received the following complaints/inquiries:

| YEAR | NUMBER OF<br>COMPLAINTS/INQUIRIES |
|------|-----------------------------------|
| 2000 | 628                               |
| 2001 | 760                               |

A review of a sample of complaints revealed that the Company resolved the complaints received in a timely and satisfactory manner. Out of the sample of 132 complaint files requested, the Company did not provide three complaint files.

The sample of complaints selected revealed that the Company overturned denials upon receipt of complaints on approximately 50% of the reviewed files. This trend was attributed by the Company to the fact that it had two different networks, PPO and HMO, where a provider could be participating in one and non-participating in the other. This, in addition to the Company's efforts to consolidate the two networks during 2000, created situations where HMO enrollees mistakenly visited a PPO provider.

A review of the complaints received subsequently, in 2002, revealed that the number of overturned claim denials based on out-of-network provider visitation declined compared to the number of complaints received during the examination period.

### ***Compliance with Agents' Licensing Requirements***

The examiners reviewed Company practices on agent licensing to determine whether the agents, who sold the Company policies, were properly licensed.

The examiners requested the licenses of a sample of 191 commission paid producers to make sure that the Company only pays commissions to properly licensed and appointed agents and agencies. The Company did not provide three of the requested commission paid producer files. The Company does not properly maintain its producer files to contain all necessary documentation supporting appointment of such producers.

For the producer licenses the Company did not provide, the examiners requested detail on the commissions they were paid. This was done to determine the appropriate contingent liability for the potential fine to be levied

by the Commissioner in accordance with ALA. CODE § 27-7-35.1 (1975), which states:

- “(a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
- (b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
- (c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this chapter at the time of the sale, solicitation, or negotiation and was so licensed at that time.
- (d) An insurer or insurance producer may pay or assign commissions, service - fees, brokerages, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate chapter 12 of this title.
- (e) Any insurer or producer violating this section shall be liable for a fine in an amount of up to three times the amount of the commission paid. The fine shall be levied and collected by the commissioner. Upon failure to pay the fine the commissioner may, in his or her discretion, revoke the license of the producer or the insurer's certificate of authority, or both.”

Commissions were paid to the following producers and the Company did not provide evidence that the following producers were licensed in the state of Alabama.

|                                    |                  |
|------------------------------------|------------------|
| Managed Benefits Inc.              | \$2414.43        |
| SGP Benefits of Texas Inc. Houston | \$ .04           |
| Professional Insurance Services    | \$ 37.45         |
| Total                              | <u>\$2451.92</u> |

According to the above-mentioned ALA. CODE § 27-8-27 (b) (1975), the Company is potentially liable for a fine totaling three times the total amount of commissions paid to the unlicensed producers. This amounts to \$7,355.76. In addition to this, the examiners' reconciliation of the commission paid producer listing to the Annual Statement revealed that the total commissions paid reported on the 2001 Annual Statement was \$37,663.38 more than what was

reported as total commissions paid in the listing. Subsequent to the on-site examination work, the Company provided another paid commissions file which the examiners did not examine or test. The Vice President of Finance, United Healthcare – Gulf States, represented to the examiners that "...To the best of my knowledge and belief, this file includes commissions paid to agents who were properly licensed in the State of Alabama, except for any findings that you might have noted already during the course of your examination. The file that I am referencing provides further detail and reduces the unreconciled difference to \$1,242.19, an amount that we believe to be immaterial..."

After further attempts by the examiners to receive more information on the reasons the above-mentioned producers were paid commissions, the Company explained that Managed Benefits Inc. was paid commissions on sales of policies issued by the Company in Virginia. The Company also explained that this was a mistake and that the Company will correct this when the group renews. A Company representative subsequently explained that the policy was not sold in error and that the Company sold the policy to a group in Alabama that is affiliated with the group in Virginia.

The Company also explained that Professional Insurance Service was actually Professional Insurance Association, which was determined to be a licensed producer by the examiners. However, the Company did not provide evidence that these two entities were the same.

The examiners also requested files of producers that sold certain policies, which were in effect during the exam period. At first, the Company did not provide the files of 22 of the requested 132 sample of selling producers. The Company does not keep all producer records at its headquarters in Birmingham Alabama, moreover; it does not properly and adequately keep its producer files to include all the necessary documentation, such as the correspondence with agents. The Company was not in compliance with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It was subsequently determined that the selected producers were licensed. The Company provided license and appointment forms on 18 of the missing producer files. The other four were confirmed as licensed by the Alabama Department of Insurance.

#### Location of Records

The Company maintained producer records in Hartford, Connecticut. This was not in compliance with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner" and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall - have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

#### Terminated Agents

During the review of the terminated agent files, the examiners requested the files of all 127 terminated agents during the examination period. The Company did not provide ten of the requested files. Out of the files provided, 45 did not have any documentation supporting the termination of the producer. The Company does not properly manage its terminated agent files; moreover, these files were kept in a location outside of the State of Alabama without obtaining the Commissioner's approval. These records should be kept in a location approved by the Commissioner and available to provide for examination purposes as required by ALA. CODE § 27-21A-6 (f) (1975), which states that:

"All records necessary for the complete examination of the health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

The examiners were not able to verify compliance with termination notification period on 55 of the 127 requested files. It was determined that the termination notification period on the other 72 terminations was reasonable and in compliance with ALA. CODE § 27-8-24 (c) (1975), which requires that:

“Upon termination of the appointment of an agent, or as soon thereafter as possible, and immediately upon completion of the insurer’s investigation, the insurer shall file with the Commissioner a written statement of the facts relative to the termination and the date and cause thereof...”

### ***Rate Filings***

The Company's rates were filed with and approved by the Alabama Department of Insurance in accordance with Section 5 of the Alabama Department of Insurance Regulation Number 79. The examiners verified with the consulting actuary that all of the Company's rate and group size factors were filed and approved by the Alabama Department of Insurance.

ALA. ADMIN. CODE 482-1-116 Section (.05) (g) (2) (2002) requires that:

"Each small employer carrier shall file with the Commissioner annually on or before March 15, both of the following:

a. An actuarial certification certifying that the carrier is in compliance with this regulation... A copy of the certification shall be retained by the small employer carrier at its principal place of business."

The Company did file the actuarial certification, but did not keep this certification at its headquarters in Birmingham, Alabama.

### **REINSURANCE**

It was noted that the Company did not submit its general liability and reinsurance policies to the Commissioner with each annual report. Therefore, the Company is in violation of Alabama Department of Insurance Regulation Number 79 Section 14, which requires: "Evidence of the existence of insurance or a plan for self-insurance approved by the Commissioner must be submitted at least 30 days prior to the expiration date of the policy and with each annual report."

The examiners determined that there were no maximum benefit limitations the Company would pay on a member in his or her lifetime. The reinsurance contract specified a maximum amount of \$2 million per member per year.

### ***Assumed Reinsurance***

The Company did not assume any reinsurance during the examination period.

### *Ceded Reinsurance*

During the course of this examination, the Company had two reinsurance agreements.

- 1.) Beginning January 1, 2000, the Company ceded reinsurance under an HMO excess risk reinsurance agreement to Continental Assurance Company.

Terms of Coverage     12 Months at January 1, 2000

Company's retention     \$150,000 deductible

Reinsurer's limits     \$1,000,000 per member per year

- 2.) Beginning January 1, 2001, the Company ceded reinsurance under a non-proportional stop loss coverage contract to United HealthCare Insurance Company.

Terms of Coverage     January 1, 2001 and continue in full force until terminated

Company's retention     \$150,000 deductible + 10% coinsurance

Reinsurer's limits     \$2,000,000 per member per year

- 3.) In addition, the Company entered into a transplant service agreement with United HealthCare Services, Inc. (UHS). The agreement was effective May 22, 1998 and will remain in effect until it is terminated.

The Company is solely responsible for the payment of all transplant services rendered to members, except for member co-payments, deductibles, or charges for services not covered under the member's benefit contract. UHS will arrange for payor's access to certain participating providers for the provision of transplant services. The benefit contracts covering transplant services, paid for pursuant to the agreement, must provide at least \$500,000 in major medical coverage during a member's lifetime and must not require co-payments, coinsurance or deductibles from members in excess of a combined total of \$10,000 for transplant services during any twelve-month period.

UHS will require participating providers to maintain and to require that all health care professionals employed by or under contract with participating providers maintain all federal, state and local licenses, certifications and permits necessary for the provision of transplant services.

### **COMPLIANCE WITH ALA. ADMIN. CODE 482-1-122**

Health maintenance organizations are not required to comply with ALA. ADMIN. CODE 482-1-122 (2002). They are, however required to be in compliance with the federal privacy law by April 14, 2003.

The Company did not share customers' personal information with any nonaffiliated third parties. Any information the Company disclosed to any third parties was for the purpose of conducting day-to-day business functions such as the payment of claims.

Instructions were in place for employees to provide guidelines for the handling of personal information the Company employees or affiliated parties might have had access to.

The Company did provide notices to its customers that indicated the types of information it collected, the way it was used and the manner of collection. The notices also informed the customers that the Company did not disclose any information to any nonaffiliated third parties unless permitted to do so by law.

The Company's disclosure of any health information was made only after authorization from its customers unless the disclosures were made under section 17B of the NAIC model regulation.

### **ACCOUNTS AND RECORDS**

#### ***General***

The Company's accounting records were maintained primarily on electronic data processing (EDP) equipment. Certain detail records were maintained solely on microfiche and Company management maintained that certain records were not available in any form other than summary records.

Management and record-keeping functions were performed by personnel and facilities of United HealthCare Services, Inc. under various management and service agreements. Further discussion on the aforementioned agreements is included in the "HOLDING COMPANY AND AFFILIATE MATTERS" section under the caption *Transactions and Agreements with Affiliates*, on page 17 of this report.

The Company was audited annually by the independent certified public accounting (CPA) firm of Arthur Andersen, LLP, Minneapolis, Minnesota, for the two-year period covered by this examination. The CPA workpapers for 2000 and 2001 were not obtained from Arthur Andersen, LLP. The Company provided copies of some workpapers that they had in their possession from 2001. It is noted that effective May 16, 2002, Deloitte & Touche, LLP was appointed as the independent public accountant for United HealthCare of Alabama, Inc. replacing Arthur Anderson, LLP.

The reserve calculations for the examination period were certified by Thomas E. Burton, F.S.A., M.A.A.A., Senior Vice President and Chief Actuary of United HealthCare Insurance Company, an affiliate of the Company. The actuarial workpapers were provided from Connecticut and were not maintained in the Company's office in the State of Alabama, as is required by Section 15 of Alabama Department of Insurance Regulation Number 79.

With the exception of some network functions and sales, the Company had no operations in the state of Alabama. The examiners' contact person for this examination was located in Phoenix, Arizona. There were no accounting personnel or detailed accounting records located at the Company's home office. The Company's records were provided from various locations outside the state of Alabama. Alabama Department of Insurance Regulation Number 79 Section 15 requires that "...Every domestic HMO shall have and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..." "...Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..."

Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

The Company routinely violated Alabama Department of Insurance Regulation Number 118 by not providing requested information to the examiners within ten working days.

### ***Claim Processing Audits***

During the examination period, the Company utilized two claims processing systems, COSMOS and UNET. On March 27, 2002, Arthur Andersen, LLP issued a report on the Uniprise UNET Claim Production. The report noted control and performance gaps and recommended solutions. Arthur Andersen issued a Network Data Management Follow-up Report on November 11, 2002 demonstrating that the Company took some corrective actions to comply with the recommendations.

It is noted that Arthur Andersen is no longer the Company's opining CPA firm; therefore, it is recommended that the Company require its current opining CPA firm to follow-up on the identified control and performance gaps to verify appropriate corrective action on all of the identified gaps and/or weaknesses.

### ***Audits by Other Regulatory Agencies***

United HealthCare of Alabama, Inc.'s 2000 and 2001 adjusted community rates (ACR) were audited by the Office of Inspector General (OIG) and PricewaterhouseCoopers, LLP, respectively. When the examiners requested the reports, the Company initially refused to provide them. Associate General Counsel of the Company provided a 2000 ACR audit final determination letter that was issued by the Department of Health and Human Services and the 2001 final determination letter issued by CMS along with an excerpt from the 2001 final report. The examiners reviewed these documents and determined that there could be both market conduct and financially significant issues discussed in these reports.

The examiners received a letter dated April 2, 2003 from a Company Compliance Manager which stated that "United's position is that the DOI does not have the legal authority to make any determinations or to review United's

compliance with the federal benefit setting process." The examiners also received a letter from Associate General Counsel of the Company, dated April 9, 2003, which stated that "...it is United's position that the state of Alabama does not have jurisdiction to review the OIG reports as part of its market conduct exam."

After the Alabama Commissioner of Insurance issued a letter to the Company on May 21, 2003 and held a meeting with the Company on June 3, 2003, the Company provided the requested information on June 3, 2003. The Company challenged the jurisdiction of the Alabama Department of Insurance to require it to submit the reports on the grounds that the State's requirement to submit those materials is pre-empted by federal law. The examiner disagreed with the Company's position as to pre-emption. The Company responded by submitting portions of the audit report to attempt to demonstrate that the issues raised in the reports were federal in nature. The Alabama Department of Insurance did not accept the legal argument and formally requested the documents again. In response to that request, the Company provided the documents.

It was determined that the 2000 and 2001 audit reports were not maintained at the Company's headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

#### ***Other examination issues***

In addition to the Company's violations (see "Issues," items 1 -- 3 below) of ALA. CODE § 27-21A-16 (1975), Alabama Department of Insurance Regulation Number 118, and Alabama Department of Insurance Regulation Number 79 the immediately preceding Report of Examination was qualified because the Company did not provide all requested information to the examiners relating to the detail of premiums; receivable balances; and the subsequent collection thereof; and the documentation, reconciliation, support and/or status of certain claims paid/payable data as of December 31, 1999. The 1999 Report of Examination also cited the Company's lack of compliance

with Alabama Department of Insurance Regulation Number 118 and Alabama Department of Insurance Regulation Number 79.

Issue Number 1 -- On February 4, 2003, the examiners requested all files pertaining to all claims benefits related litigation that was initiated between January 1, 2000 and December 31, 2001. On February 13, 2003, a Company Compliance Manager stated in an email "In response to your request for the file pertaining to all the litigations (sp) within the listing we provided, we are not able to provide you with complete access to the files, because the files contain attorney work product, as well as material subject to the attorney-client privilege." Without the litigation files, the examiners could not determine what liabilities may exist in relation to litigation. In addition, it was noted that the litigated claims files were located in Minnesota.

After the Alabama Commissioner of Insurance issued a letter to the Company on May 21, 2003 and held a meeting with the Company on June 3, 2003, the Company provided portions of the requested information.

Issue Number 2 -- At December 31, 2002, the Company had no operations in Alabama except for 53 employees that relate primarily to network management and sales. None of these personnel were involved in the accounting, investment or claims functions of the Company. Items received from out-of-state included, but were not limited to the following:

- Premium invoices and premium histories
- Reinsurance contracts
- Accounts receivable for uninsured A&H plans
- Tax agreements and supporting workpapers
- Surplus note approval letter
- Capital stock ledger
- General ledger details
- Bank statements
- Canceled checks
- Conflict of interest statements
- Valuation of Securities information, including SVO certification and PE security files.
- Custodial agreements
- Management agreements with external parties
- Agents files
- Complaints files
- Reinstatement files

Litigated claims files  
Outstanding check list

Issue Number 3 – In addition to the records not being located in Birmingham, Alabama, there are several instances cited within this report where the Company did not provide requested items. The number of items not provided to the examiners in their statistical samples was outside the parameters of an acceptable number of exceptions.

The more material instances of the Company not providing certain requested items are documented below. More in-depth discussion is included throughout this examination report:

### **Claims Payment Practices**

Supporting documentation for 39 pharmacy claims

### **Bonds**

Brokers Advices for 36 transactions made during 2001

### **Compliance with Agents' Licensing Requirement**

Licenses and appointment forms for three commission-paid agents

Files for ten of the producers that were terminated during the examination period

45 of the requested 127 terminated producer files provided did not have any documentation supporting the termination.

Files containing the licenses and appointment forms for four policy-selling agents.

### **Policyholder complaints**

Three complaint files

### **Claims unpaid**

Documentation to support that claims payments were made according to contractual agreements for 21 of 47 claims sampled.

Claims files to support two of 47 unpaid claims sampled.

Canceled checks to support two of 47 unpaid claims sampled.

Claims files and documentation to support two large claim adjustments.

Reconciliation of claims payment to cash disbursements journal for four of 47 unpaid claims sampled.

Appropriate supporting detail (including policy level detail where applicable) for all amounts that composed \$26,974,165 of \$318,729,674 in claims paid - recorded in the Underwriting and Investment Exhibit- Part 2B.

Out of a sample of 47 paid claims, the Company did not provide twelve.

### **Accrued Medical Incentive Pool and Bonus Payments**

Contracts for providers who participated in the Medicare PCP (Primary Care Physician) Bonus payment program

### **SUMMARY:**

ALA. CODE § 27-21A-16 (f) (1975), requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

Alabama Department of Insurance Regulation Number 118 requires that: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Alabama Department of Insurance Regulation Number 79 Section 15 requires that:

“An Alabama domiciled (domestic) HMO shall keep all necessary records in an Alabama location required for the efficient examination of its financial condition and health care delivery system. These records shall include but not be limited to the general ledger and subsidiary ledgers, management contracts, provider contracts, enrollment records, utilization records, group contract records, premium records, quality of care documentation records and complaint records...”

“Every domestic HMO shall have and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted...”

“Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner’s written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975...”

Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as “Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer.”

## **FINANCIAL STATEMENTS INDEX**

See Pages 97-99 for the Statement of Assets, Liabilities, Capital and Surplus, Statement of Revenue and Expenses, and Statement of Net Worth as reported by the Company in its filed Annual Statements.

## **EXAMINATION FINDINGS**

The notes that follow represent items which indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

### **Note 1 - Bonds**

**\$102,253,104**

The captioned asset is \$260,417 less than the \$102,513,521 reported by the Company in its 2001 Annual Statement.

The Company reported the NAIC designation of one bond with a book value of \$260,417 as "ZZ" in column 13 of *Schedule D - Part 1*, which indicated that the security had not been filed with the NAIC Securities Valuation Office (SVO). Alabama Department of Insurance Regulation Number 98 Section 2(A) requires that any security not valued in accordance with standards promulgated by the SVO be carried as a non-admitted asset until such time that the insurer has complied with the standards.

The Company indicated that a Security Acquisition Report (SAR) was not filed on this bond. This bond was purchased on March 14, 2001, at which time the Company had 120 days to file a SAR with the SVO. Utilizing this guideline, the examiners determined that the security should be non-admitted in accordance with Alabama Department of Insurance Regulation Number 98 Section 2(A).

The examiners were informed by the Company that there was no proof that the custodial agreement with Compass Bank, in force during the examination period, was approved by the Commissioner. After further investigation, the Alabama Department of Insurance confirmed that the custodial agreement with Compass Bank dated December 1996 was indeed approved. The Company did not have evidence of approval on file at its headquarters, which is in conflict with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

A new agreement with Compass Bank was created and submitted to the Department for approval on April 21, 2003, and was approved April 30, 2003.

During the examination it was discovered that the Company did not file a SVO certification for the year 2000 as required in the NAIC Annual Statement Instructions for 2001:

"There is to be completed and attached to each quarterly and annual statement of the Company a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion."

The Company is using a modified scientific method of amortization instead of the required scientific method, which is not in accordance with the NAIC Accounting Practices and Procedures Manual SSAP 26 Section 6 that states:

"Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

The Company adds the cost of accrued interest paid at purchase to the actual cost of the security in calculating effective yield. Effective yield is a key component in the Scientific Method Calculation. The NAIC Annual Statement Instructions provide that Book/Adjusted Carrying Value is to be calculated at:

"The original cost of acquiring the bond, including brokerage and other related fees, to the extent they do not exceed the fair market value at the date of acquisition. Amortization of premium or accrual of discount, but not including any accrued interest paid thereon."

During the examination period, the Company did not maintain complete documentation concerning its investment transactions, including the preservation of all brokers' advices received from the investment institution making transactions on behalf of the Company, as required by ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal

place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It was also noted that the Company was unable to provide sampled brokers' advices in a timely manner. The first request for the brokers' advices was made on March 26, 2003. The Company was only able to provide five of the 47 brokers' advices. Six of the 47 sampled brokers' advices were paydowns on securities so there were no brokers' advices. This failure to provide the sampled broker's advices is a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

**Note 2 - Cash**

**\$23,624,376**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. It was noted that the Company's Regions Bank reconciliation did not include the -\$792.00 account balance located in the zero balance account that is tied to the Regions Checking account. This amount was immaterial so no adjustment needs to be made to the financials contained in the report.

It was noted that the Company collected premiums for its UNET system in Chicago, IL and Newark, NJ at United HealthCare Insurance Company. The premiums are remitted to United HealthCare of Alabama, Inc. with intercompany settlements that occur throughout the month. It was also noted that the Company collects its past due premiums in Lake Mary, Florida. The Company should not allow funds to be deposited outside of the state of Alabama nor should the premiums be routed to a lockbox that is not owned and controlled by United HealthCare of Alabama, Inc. The Company is in violation of ALA. CODE § 27-21A-6 (c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..." The Company is also in violation of ALA. CODE § 27-27-29 (b) (1975), which states that "Every domestic insurer shall have, and maintain, its assets in this state..."

In reconciling the total interest received to the Underwriting and Investment Exhibit, Part 4 of the 2001 Annual Statement, the examiners discovered that the Company had neglected to include on the Schedule E, interest that had

been received from two US Treasury Bills. This interest totaled to \$6,076.00 and was included in the Underwriting and Investment Exhibit, Part 4, Page 15, Column 1, Line 5.1 of the 2001 Annual Statement.

The examiners requested a listing of the outstanding checks as of December 31, 2001. This request was sent on February 6, 2003. On February 17, 2003, the examiners received the listing in microfiche format, but the Company had no machine on site to print out or read the information in this format. On April 17, 2003, the examiners received a hard copy of the listing. The listing consisted of 524 pages of information. It was determined that UnitedHealth Group, Incorporated receives an electronic copy of the outstanding check list, which is reconciled with the bank statement. UnitedHealth Group, Incorporated then keeps one copy of the outstanding check list in Hartford Treasury in Connecticut, and one copy at Health Plan Accounting in Minnesota, both in microfiche format. The examiners found that the outstanding checks are not kept in electronic format by the Company. The list of outstanding checks was being stored in the form of microfiche, which makes the information very difficult and time consuming to recover. The Company does not have, nor can they create an electronic copy of the outstanding checklist.

It was also noted that the information took more than ten days to be sent to the examiners and that the list is being maintained outside of the state of Alabama. The delay in receiving the information constitutes a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The list of outstanding checks not being maintained in the state of Alabama constitutes a violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**Note 3 - Accident and Health Premiums Due and Unpaid** **\$0**

The captioned amount is \$415,046 less than the \$415,046 reflected in the Company's 2001 Annual Statement. The following schedule represents the premium receivable asset, at December 31, 2001, and the examination adjustment:

|                                    | Per the<br>Company | Per the<br>Examination |   |
|------------------------------------|--------------------|------------------------|---|
| Premium Receivables                | \$4,527,513        | \$2,504,617            |   |
| Premium Receivables (over 90 days) | 1,576,781          | 3,599,677              |   |
| Total Premium Receivables          | 6,104,294          | 6,104,294              |   |
| Premium Clearing account           | -1,026,621         | -1,026,621             |   |
| Not admitted premiums over 90 days | -1,576,781         | -3,599,677             |   |
| Allowance for doubtful accounts    | <u>-3,085,847</u>  | <u>-1,477,996</u>      |   |
| Premium Receivable admissible      | \$ 415,046         | \$ 0                   | - |

The examiners determined that the Company had receivables over ninety days in the amount of \$3,599,677. Per the Company's 2001 Annual Statement, the Company only non-admitted \$1,576,781. The examiners noted that the Company did not non-admit all premium balances over ninety days in accordance with the SSAP No. 6, paragraph 9. This issue was also addressed in the previous two examination reports.

Instead of non-admitting the entire \$3,599,677 as required by SSAP No. 6, the Company only non-admitted \$1,576,781 and maintains that they included the remaining \$2,022,896 in their "Allowance for doubtful accounts." The total that the Company established for its allowance for doubtful accounts was \$3,085,847.

The Company did not provide the examiners with supporting documentation that reconciled to the \$3,085,847 Allowance for doubtful accounts. Therefore, the examiners:

- 1.) Non-admitted the entire \$3,599,677 in premiums that was over 90 days.
- 2.) Reduce the allowance for doubtful accounts to \$1,477,996 in order to not bring the admitted balance of premiums due and unpaid below zero.

It was determined that the Company did not keep complete records of its premiums receivable. It was also determined that the premium receivable data sets were not maintained at the Company's headquarters in Birmingham,

Alabama. The Company was not in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**Note 4 - Healthcare Receivables**

**\$0**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

It was determined by the examiners that the Company had loaned \$130,000 to Radiologist PC. This money was to be paid back to the Company in 13 consecutive equal monthly installments of \$10,000 beginning on December 10, 2000. It was determined that no interest was charged on the loan. The Director of Network Management explained that the purpose for the loan was that at that time United Healthcare was struggling to pay Radiologist PC's claims according to their contract and the group was threatening to cancel their contract which would have resulted in a "gap." Another email from the Director of Network Management stated that the group's contract was non-standard and there was difficulty programming the reimbursement structure into the claims system.

**Note 5 - Amounts recoverable from reinsurers**

**\$80,815**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

The examiners reviewed United HealthCare Insurance Company's (UHIC) 2001 Annual Statement to confirm the reinsurance recoverable directly. It was noted that UHIC did not record a payable at year-end 2001 while United HealthCare of Alabama recorded a receivable of \$80,815.

**Note 6 - Amounts due from parent, subsidiaries, and affiliates**

**\$222,516**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. In the previous examination report, the examiners noted that the Company netted all affiliate settlements through United HealthCare

Corporation's Intercompany Clearing Segment. In the Intercompany Settlement Clearing Segment, all intercompany settlements are centralized through a clearing segment. The clearing segment is used to net the multiple intercompany payable and receivable obligations for each entity into a single balance. NAIC Annual Statement Instructions stipulate that amounts due to or from affiliates can be offset and reported net. However, receivables and payables must be reported separately if amounts are due from different affiliates in accordance with guidelines established in the NAIC Accounting Purposes and Procedures Manual.

**Note 7 - Amounts receivable relating to**  
**uninsured accident and health plans** **\$0**

The captioned amount is \$250,024 less than the \$250,024 amount reported by the Company in its 2001 Annual Statement.

It was determined by the examiners that the Company recorded receivables from affiliates for the University of Alabama at Birmingham (UAB) in the amounts receivable relating to uninsured accident and health plans line item. Per the Vice President of Finance, UAB was an uninsured plan for which the membership and revenue resided on United HealthCare Management Company. During 2001, the Company paid claims on behalf of United HealthCare Management Company for UAB with UAB providing reimbursement to the Company. Since UAB was not a group of the Company, the entire balance of \$236,195 was non-admitted.

It was noted that the Company recorded receivables for Birmingham News in the accounts receivable relating to uninsured accident and health plans line item. However, Birmingham News was a fully insured group. The balance appearing in the uninsured plans related to supplemental coverage for Birmingham News. The Company was paying the deductibles for Birmingham News' executives and Birmingham News was reimbursing the Company back for the deductibles that were paid. This balance of \$13,829 was non-admitted because there were no formal arrangements for the Company to pay the deductibles.

It was noted that the Company did not maintain the detail for its uninsured plans, therefore not complying with Section 15 of Alabama Department of Insurance Regulation Number 79 which states:

"...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..."

The Company was also in violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

**Note 8 - Receivable for securities**

**\$34,600**

The captioned amount is the same as reported by the Company in its 2001 Annual Statement. It was determined by the examiners that the Company had recorded money market cash interest payments due and accrued in the - Receivables/Payables for Securities Account. According to the NAIC Annual Statement Instructions for Health Insurance Companies, contents of this account should include, "amounts received within 15 days of the end of the period that are due from brokers when a security has been sold, but the proceeds have not yet been received." The interest payments should have been recorded in the Investment income due and accrued line item. The amount recorded as a receivable was immaterial.

**Note 9 - Federal and foreign income tax recoverable**

**\$2,815,545**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

It was noted that the Company included the total change in net deferred tax along with the total current federal income tax provision as income tax provision on the statutory statement of operations. The total change in net deferred tax should have been reversed out of the income statement and netted against retained earnings/surplus in accordance with SSAP No. 10, paragraph 7. Per SSAP No. 10, paragraph 7, "Changes in deferred tax assets and deferred tax liabilities, including changes attributable to changes in tax rates and changes in tax status, if any, shall be recognized as a separate component of gains and losses in unassigned funds (surplus)..."

**Note 10 - Claims unpaid****\$47,580,808**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. During the review of the unpaid claims liability, the Company provided policy level detail and general ledger detail in order to validate the amount of the liability. The policy level detail was provided from the Company's two claims processing systems, COSMOS and UNET. In requesting the detail, one of the fields that was to be included in the datasets was the check issued dates. For the COSMOS detail, the Company did not include the check issued dates in the dataset. For the UNET detail, the Company did include the check issued dates in the dataset. After selecting a sample from the 2001 unpaid claims detail and reconciling to the payments made in 2002, the examiners found that some of the claims sampled had paid dates before December 31, 2001. Because the detail from both claims processing systems did not include the check issued dates, the examiners were unable to determine the amount that the liability was overstated. The examiners did determine that the claims liability in relation to the UNET claims processing system was overstated by \$10,703.

Also during the review of the unpaid claims liability, the examiners selected a sample of 47 items from the claims detail in order to verify the accuracy of the detail with the claims files and trace the payments made in 2002 to the cash disbursements journal and canceled checks. For two of the UNET claims sampled, the check issue dates from the claims detail were not consistent with dates found on the canceled checks.

The examiners also noted that the Company did not maintain any documentation to support the unpaid claims liability at its home office in Birmingham, Alabama. This problem was noted in the preceding examination report issued by the Alabama Department of Insurance.

During the review of the claims paid during 2001, the examiners requested policy level detail to support the amount of paid claims reported in the Underwriting and Investment Exhibit, Part 2B, columns 1 and 2, line 11. Of the \$318,729,674 of paid claims reported, the Company did not provide appropriate supporting detail (including policy level detail where applicable) for all amounts that composed \$26,974,165. The Company provided general ledger activity to support this amount. The preceding report of examination noted this same problem.

After reconciling the 2000 and 2001 general ledger activity and paid claims detail from the COSMOS and UNET claims processing systems to the 2000 and 2001 Annual Statements, the examiners scanned the general ledger activity and detail for any unusual amounts (i.e. large claim payments and large claim adjustments). From scanning the ledger activity and claims detail, the examiners found and requested the detail to support 43 claims. These 43 claims were significantly higher than the other claims payments and claims adjustments in the general ledger and claims detail. The Company was unable to provide supporting documentation for two of the 43 claims requested within ten business days in accordance with the Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The examiners also noted that the Company did not maintain any documentation to support the amount of claims paid at the home office in Birmingham, Alabama. The preceding report of examination noted this same problem.

In a separate procedure, the examiners selected a sample of 47 claims in order to verify that the payments were made in accordance with the contractual terms between the Company and provider or pharmacy. The examiners requested claims files and payment schedules in order to verify that the amounts of the payments were according to the contractual agreements. The examiners found the following for the 47 items sampled:

- For 26 of 47 claims sampled, the Company was able to provide payment schedules to show how much the Company paid per procedure and/or service based on the physicians contracted rates.
- There was one pharmacy claim adjustment in which the Company was unable to provide any supporting documentation.
- The other twenty claims sampled were pharmacy claims. The Company has an agreement with United Healthcare Services to provide administrative services relating to pharmacy management and claims processing for its enrollees. United Healthcare Services contracts with Merck-Medco Managed Care for provision of these services. The Company provided screen prints from Medco to show the calculation of each claim payment. The examiners obtained the Pharmacy Benefit

Management Agreement between United HealthCare Services and Merck Medco Managed Care, L.L.C. as well as group contracts for the enrollees included in the sample. The payment of claims, according to the Pharmacy Benefit Management Agreement, Financial Appendix, Section 1, is based on one of the three scenarios:

"United HealthCare will pay PBM(Medco) for covered Prescription Drug in an amount equal to the lowest of the following minus covered Person's Co-payment: (a) the pharmacy's usual and customary price, as submitted, (b) the maximum allowable cost, where applicable plus dispensing fee, or (c) the network's applicable AWP (average wholesale price) minus discount plus dispensing fee."

The amount paid to PBM by United HealthCare Services, Inc. is the amount that PBM pays on behalf of the Company for pharmacy claims. In order to determine that claims were being paid according to the contract, the examiners first determined the amount of co-payment by reviewing the certificate of coverage for each group sampled. Next the examiners were to calculate amounts for (a), (b), and (c) from the contracts language and determine which amount was the least. The Company was unable to provide all information needed to figure the amounts for scenarios (b) and (c). Therefore the examiners were unable to determine if these payments were made according to contractual terms.

The examiners also selected another sample of 47 claims from the unpaid claims detail. The examiners used this sample in order to reconcile information provided in the unpaid claims detail to the actual claim files and canceled checks. The Company provided the claims files for 45 of the 47 items sampled. The two outstanding claims were pharmacy claims. The Company has an agreement with United Healthcare Services (UHS) to provide administrative services relating to pharmacy management and claims processing for its enrollees. United Healthcare Services contracts with Merck-Medco Managed Care (Medco) to pay all pharmacy claims for the health care plans under United Healthcare Services. Since Medco is contracted to pay the pharmacy claims for UHS as well as other nonaffiliated health care providers, Medco's claims payments to individual pharmaceutical companies is grouped together for all health care providers with whom they have contracts. Therefore, the Company contends that it would be too much trouble to track these claims in order to provided canceled checks. The Company was not able to provide the claims files and canceled checks in order for the examiners to

verify the claimed amounts, policy number, provider name and code, service code, line of business, dates of service, claim received date, claimed amount paid and date from the database. Failure to provide information necessary for the examination is a violation of Alabama Department of Insurance Regulation Number 118, Section 6 which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The examiners asked how the Company can prove to a claimant that a pharmacy claim has been paid if the Company was unable to provide the examination team with the requested documentation. The Company should have a database or the ability to query a database by policyholder and/or claim amount that ties back into specific "batch" payments which ultimately ties back into a canceled check or wire transfer. Without the ability to do this, the Company does not have the ability to vouch its payments for pharmaceutical claims to any outside source.

For the two outstanding pharmacy claims, the examiners were informed by the Company contact that "Given the amount of time it will take to pull the requested documentation to indicate how the pharmacy claim payments tie to the United HealthCare general ledger, we [the Company] will not be providing the sample items requested. As was noted during the conference call, United HealthCare pays Medco for all pharmacy claims; Medco in turn pays the pharmacies. United HealthCare maintains pharmacy claims payment data can be used to prove to Medco that a pharmacy claim has been paid. Medco maintains pharmacy claims payment data that can be used to prove to a pharmacy that a pharmacy claim has been paid."

Also for the sample above, the examiners were to trace the claims payment into the cash disbursements journal. Of the 47 items sampled, 43 items were sampled from the COSMOS claims processing system and four items were sampled from the UNET claims processing system. For the four items sampled from the UNET claims processing system, the Company was unable to provide any documentation from within the cash disbursements journal of the payment of these four claims.

The previous examination recommended that the Company maintain all detailed information supporting the claims paid and claims payable reported in

Schedule H of its future financial statements. This recommendation has been made again during the current examination.

**Note 11 - Accrued Medical Incentive Pool**

**\$35,000**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. The examiners reviewed the General Interrogatories to verify the completeness of the information disclosed. Line 9.1 of the General Interrogatories- Part 2 in the 2001 Annual Statement states that the Company had bonus/withhold arrangements in its provider contracts. The examiners requested a copy of the Medicare PCP bonus agreement between the Company and the participating providers. The examiners were informed that only fee for service primary care physicians (PCP) participated in this bonus program at the discretion of the Company and there is not a contractual arrangement. The examiners note that because the Company was unable to provide a contractual agreement, the examiners could not determine if an adequate amount for this liability was established or if the Company was paying only the appropriate providers.

During the review of the Medicare PCP bonus program, the examiners were to select a sample of provider contracts to ensure that withhold percentages and calculations were in accordance with provisions contained in the contracts. The Company does not have a contractual agreement with the providers who participate in the Medicare PCP bonus program but paid \$2 per member per month for servicing Medicare members. The Company did not provide a report as of December 31, 2001, to verify the number of Medicare members serviced during the fourth quarter 2001. The report that was provided was as of June 25, 2003, which included additional members serviced since December 31, 2001 for some of the participating physicians. Therefore, the examiners were unable to verify the actual number of Medicare members serviced during the fourth quarter 2001 for all of the physicians sampled. The examiners also found that the fourth quarter report did not include one of the 47 participating physicians sampled. The examiners noted that the Company terminated the physician from the report in error and provided documentation to show that the provider's membership with the Company was in effect as of December 31, 2001.

On June 5, 2003, the examiners requested a detailed listing of providers with whom the Company had withhold or medical incentive pool arrangements under the Physician Incentive Allowance (PIA) agreement in 2000 in order to ensure that withhold percentages and calculations were in accordance with

provisions contained in the contract. On July 28, 2003, the examiners were provided the listing of physicians who participated in the PIA agreement during 2000. The PIA agreement was terminated on January 1, 2001. Because the listing was not provided in an adequate enough time to select a sample, request information to accomplish the procedure, and review the detail provided before the completion of the examination, the examiners were unable to accomplish the procedure. The failure to provide the information within 10 working days was a violation of the Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

**Note 12 - Premiums received in advance**

**\$19,445,231**

The captioned amount is the same as reported by the Company in its 2001 Annual Statement.

The examiners requested a sample of 47 premiums received in advance on March 13, 2003. The Company provided a response that stated that six of the 47 groups were billed individually. The Company provided three of the six individually billed groups because the groups did not have many individuals within the group. The examiners received a response on April 7, 2003 that stated that the Company was not going to provide the other three individually billed groups because it would take an extraordinary amount of work to provide the auditable details requested. On May 30, 2003, the examiners received the requested items. The Company did not comply with ALA. CODE § 27-2-23(b) (1975), which states: "Every person being examined, its officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner or his examiners the accounts, records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination."

In addition, the Company was not in compliance with Alabama Department of Insurance Regulation Number 118, Section 6, which states "The insurer shall provide, within ten (10) working days, any records or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The Company also made a cash application error. The Company recorded an amount in an Alabama account that was actually a Mississippi account. However, the amount was properly reversed and applied correctly to a Mississippi legal entity. See "Premium Allocation Agreement" – Page 19 for a related discussion.

**Note 13 - General expenses due or accrued**

**\$661,688**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. A payment to Balch and Bingham LLP, made on January 7, 2002 and invoiced on October 19, 2001, was not recorded in this line item for 2001. This transaction was recorded in the general ledger on the date that it was paid. Company management indicated that "Legal fees that are not covered by insurance are not accrued for because of the relatively low dollar volume. These legal fee invoices are processed and reflected on the general ledger in the month they are paid." The amount of this transaction was deemed to be immaterial.

See "Commitments and Contingent Liabilities" – Page 69 for related discussion.

**Note 14 – Unassigned funds (surplus)**

See Pages 97-99 for the financial statements of the Company, as reported in the Annual Statements filed with the Alabama Department of Insurance.

**COMMITMENTS AND CONTINGENT LIABILITIES**

At December 31, 2001, the Company accrued \$1,400,000 for settlements on two outstanding cases. These amounts were included in Claims Unpaid on the 2001 Annual Statement because these cases were provider claim disputes. There were no other amounts accrued.

Company management indicated that "Legal fees resulting from the following litigation are covered by insurance and would require no accruals on the health plans general ledger. Medical Malpractice (direct and vicarious) Breach of Duty benefit disputes (cost to defend and extra damages, if applicable). Provider disputes (cost to defend and extra damages, if applicable). Legal fees resulting from the following litigation are not covered by insurance. employment

matters regulatory matters. Because of the relatively low dollar volume, the Company does not accrue legal fees for these types of litigation. The invoices are processed and reflected on the general ledger in the month they are paid."

While the examiners acknowledge that legal fees have not routinely been a material amount, the preceding report of examination specifically recommended that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date. Therefore, the Company did not comply with this recommendation. Company management responded that they accrue known, material liabilities at year-end and that it was their opinion that these types of fees were generally not known or material.

All legal invoices were maintained and provided from Golden Valley, Minnesota. The examiners requested (in writing) legal invoices on April 18, 2003 and they were provided May 7, 2003.

In addition, the examiners reviewed the legal invoices and determined that the documentation provided did not demonstrate that 42 of the 58 payments made in 2001 and 16 of the 27 made in 2002 actually were the responsibility of United HealthCare of Alabama. The examiners again requested adequate supporting documentation on May 9, 2003. Additional information (which confirmed multiple errors in payments made in 2001 and 2002) was provided on August 1, 2003.

ALA. CODE § 27-21A-16 (f) (1975), requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

Alabama Department of Insurance Regulation Number 118 requires that "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Alabama Department of Insurance Regulation Number 79 Section 15 requires that: "An Alabama domiciled (domestic) HMO shall keep all necessary records in an Alabama location required for the efficient examination of its financial condition and health care delivery system. These records shall include but not be limited to the general ledger and subsidiary ledgers, management contracts, provider contracts, enrollment records, utilization records, group contract records, premium records, quality of care documentation records and complaint records..." "Every domestic HMO shall have and maintain, its

principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..." "Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..." Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

In addition, the Director of Risk Management, UnitedHealth Group, Inc., represented that "United HealthCare Services pays insured legal expenses for the Health Plan." Uninsured expenses (generally provider fees and benefit costs as well as regulatory matters and employment liability) are charged to the Health Plan. United HealthCare of Alabama does not pay legal costs for insured matters. Those invoices are paid by United HealthCare Services. Since United HealthCare Services pays the costs reference [sp] above, payments made by insurers are reimbursed to United HealthCare Services."

This practice results in the Company's books and records not accurately reflecting its legal expenses. United HealthCare Services is purchasing insurance for the expenses of the Company and then collecting those insurance proceeds instead of those transactions flowing through the accounts and records of the Company. H&W Indemnity, Ltd. is a Cayman Islands affiliate of the Company and is one of the insurers that United HealthCare Services is purchasing insurance from. The Company did not provide the examiners with evidence that H&W Indemnity is approved to write business on any kind of basis in the United States.

In addition, it was noted that, contrary to representations by the Director of Risk Management, employed by UnitedHealth Group, Inc., the Company paid certain expenses that should have been covered by the insurance policies purchased by UnitedHealth Services.

The pleadings were maintained and provided from Edina, Minnesota by Associate General Counsel for UnitedHealthcare, A UnitedHealth Group Company.

The litigation files that were provided were redacted. Associate Counsel for the Company stated that "it was agreed that United HealthCare of Alabama would submit certain litigation documents but would redact any data protected by the attorney-client or work product privileges. The redacted information would be identified in a privilege log. We have supplied the information from litigation files in response to the Department's request, and decline to disclose the redacted information because it is privileged. Explanations of why these documents are considered privileged have been supplied by counsel in a separate e-mail." The Company's editing of their litigation files went beyond the examiners' expectations and included the redaction of "work done under the direction of legal counsel in preparation for the litigation" and communications to its liability carrier.

The examiners requested and received letters from outside counsel. The firm of Weil, Gotshal & Manges LLP, New York, NY disclosed a case that was not disclosed by Company management or by Company Counsel. The letter identified a nation-wide class action lawsuit that could have implications for the Company. It does not appear that the Company is named directly in the lawsuit; however, United Healthcare, Inc. and UnitedHealthGroup Incorporated are named. The plaintiffs, which are health care providers that have contractual relationships with at least one or more of eight defendant managed care companies, allege ten causes of action against the defendants generally arising out of the manner in which physicians are reimbursed for their services. The claims include multiple violations of RICO, claims for benefits under ERISA, breach of contract, Medicare Prompt Payments laws, unjust enrichments, and violation of state prompt payment statutes. The allegations to support RICO claims include allegations of mail and wire fraud, ERISA kickbacks, extortion and violation of the Travel Act.

Associate General Counsel for the Company provided the examiners with a listing of benefits-related litigation that arose between January 1, 2000 and December 31, 2001.

The following differences were noted between Associate General Counsel's listing and the pleadings provided:

- 1.) The Graves Settlement was settled for approximately \$4600 more than the \$2500 disclosed by the Company's attorney.
- 2.) The Powell case settled for \$500 more than the \$4600 disclosed by the Company's attorney.

- 3.) The Nix case settled for \$1093 more than the \$1000 disclosed by the Company's attorney.
- 4.) The Harvey case settled for \$1000 more than the \$1526 disclosed by the Company's attorney. The \$1000 was to cover Ms. Harvey's legal fees.

The examiners received a response from the Company's Deputy General Counsel, on February 17, 2003. The response was deemed incomplete because the Deputy General Counsel failed to provide the present status of each identified case and an opinion on the amount and probability of ultimate payment of each item. We sent a follow up to the Deputy General Counsel on February 27, 2003. We received a revised response from the Deputy General Counsel on April 11, 2003. This response included additional information including status and opinion on the amount and probability of ultimate payment on each case. Also, he added certain Medicare-related litigation that was originally "inadvertently omitted" and he deleted one case because the Company filed suit and wasn't being sued.

Cases disclosed by the Deputy General Counsel with differing information included:

Brown – The Deputy General Counsel indicated a little over \$2,000 - the file reflected claims payments of \$3,178.50. The Deputy General Counsel did not provide a reason for the discrepancy; however, Associate General Counsel stated that "it appears that there were two separate claims paid: the hospital claim for \$2084, which was the claim at issue in the suit, and then a related claim, subsequently demanded by the doctor, for \$1094. The Company's files indicated that these claims were settled at the same time with the same documents.

Neither Associate General Counsel nor Deputy General Counsel's listing included the Mobile Infirmary case and settlement. Associate General Counsel initially responded that "Mobile Infirmary was not included on my list because it was not a benefit-related suit (it was a dispute revolving around the provider contract). It was not included on Tim's list, because it settled prior to December 31, 2001." The examiners' review of the Company's file indicated that the settlement agreement was dated December 14, 2001. The Company was in violation of the settlement agreement at December 31, 2001 because the settlement was not paid until January 2002. The case was not dismissed until January 28, 2002. Associate General Counsel then responded that it was the

Company's interpretation that we didn't want any cases other than benefit-related lawsuits. We provided her with the e-mail which requested "The listing of litigated claims should be a list of all benefit-related suits filed by either enrollees or providers. If these are two different listings, please provide both." Associate General Counsel did not provide any additional information.

In addition, neither Associate General Counsel nor Deputy General Counsel disclosed an arbitration award against the Company in March 2001, which resulted in the Company paying \$3,145,000. This was identified by the examiners when investigating a significant variance in the legal expenses for the year 2001.

The examiners requested that the Company provide, as originally requested, a listing of all litigation. This was requested on May 8, 2003. After a meeting with the Alabama Department of Insurance Commissioner, the Company provided the examiners with a listing of litigation that the Company's General Counsel represented was complete.

The pleadings were maintained and provided from Edina, Minnesota.

## **SUBSEQUENT EVENTS**

It was noted that the Company hired Dr. Evangeline R. Franklin, M.D. on February 24, 2003 with the intent that she would serve as the Medical Director in Alabama. On March 3, 2003, the Board of Directors elected Ms. Franklin as the Medical Director to replace Dr. Larry B. Amacker, M.D. In May 2003, it was noted that Dr. Franklin was not qualified to serve as the Medical Director in Alabama. On the date the board officially appointed her as the Alabama Medical Director, Dr. Franklin was not a licensed Alabama physician nor had she applied for such license. Dr. Franklin was only licensed in Louisiana. The Alabama Department of Public Health Rule Number 420-5-6.11(2)(a) requires that the Company's medical director hold an Alabama license or have an application on file at the time of her appointment. On May 12, 2003, the Board of Directors reversed the election and reinstated Dr. Larry Amacker, M.D. until Dr. Franklin obtains her license in Alabama.

### **Dividends:**

It was noted that the Company declared dividends in the amount of \$32.8 million and \$39 million on July 15, 2002 and April 10, 2003, respectively.

### **Changes in administration:**

The Company transferred its commercial consumer affairs research and resolution function to an Ohio office, effective April 1, 2002. The Company also transferred its Medicare appeals and grievance function to Tampa, Florida.

The following COSMOS functions were transferred from Lake Mary, Florida to Duluth, Minnesota in March and April 2003.

- Eligibility (Member Enrollment)
- Billing and Support
- Case Installations

On March 11, 2003, Mr. Charles C. Pitts notified the Corporation that he shall resign as Chairman, President and Chief Executive Officer of the Corporation effective June 30, 2003. On May 27, 2003, Mr. T. David Lewis was elected to serve as Chairman, President and Chief Executive Officer of the Corporation effective July 1, 2003.

On July 21, 2003, the Company's Medicare related customer service functions were relocated to the Medicare service center in Sunrise, Florida.

On July 28, 2003, the Company's National Appeals Service Center relocated its Southeast Region Complaints/Grievances function from Dayton, Ohio to Duluth, Minnesota. The Department of Insurance Complaints will also relocate to Duluth, Minnesota on or around December 8, 2003.

### **COMPLIANCE WITH PREVIOUS RECOMMENDATIONS**

A review was conducted during the current examination with regard to the Company's compliance with recommendations made in the previous examination report. This review indicated that the Company had not satisfactorily complied with the prior recommendations as listed below:

**Bonds** - In the previous exam, it was recommended that the Company maintain complete records of its assets, transactions and affairs in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79 and ALA. CODE § 27-21A-16(f) (1975). It was also noted that a similar recommendation was made in the exam preceding that exam. Failure to comply with this recommendation was evident in the Company's failure to provide the complete sample of brokers' advices. It was also evident in the

Company's failure to provide proof of the Compass Bank custodial agreement approval by the Alabama Department of Insurance. The Company originally said that the agreement was not approved because they could find no proof of the approval in their records. The examiners requested information from the Alabama Department of Insurance and determined that the agreement was approved.

**Cash and short-term investments** - It was noted in the last exam that the Company was using several bank accounts located in other states. The Chase Manhattan Bank is based out of New York, New York. During the exam period, the Company used this account for claims payment clearing and premium receipt. The final check written on the Chase account was on August 28, 2000, but wire transfers of premiums to this account continued until December 31, 2002. Balances per the bank statements at December 31, 2001, amounted to \$0.00. Also the account statements for all accounts, except for the Compass Custodial Statement, were received from outside the state. This account remaining active, along with the majority of the bank account statements being kept in Minnesota, continues to represent a violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**Accident and health premiums due and unpaid** - The Company did not non-admit all account balances ninety days past due in accordance with the NAIC Accounting Practices and Procedures Manual.

The Company did not maintain all detailed information supporting the premium receivable amount reported in its 2001 Annual Statement. The Company could not provide all detail for its premium clearing account.

The Company did not maintain complete records supporting the premium receivable amounts at its Alabama home office in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79.

**Amounts due from parent, subsidiaries and affiliates** - In the previous examination report, the examiners noted that the Company netted all affiliate

settlements through United HealthCare Corporation's Intercompany Clearing Segment. In the Intercompany Settlement Clearing Segment, all intercompany settlements are centralized through a clearing segment. The clearing segment is used to net the multiple intercompany payable and receivable obligations for each entity into a single balance. NAIC Annual Statement Instructions stipulate that amounts due to or from affiliates can be offset and reported net. However, receivables and payables must be reported separately if amounts are due from different affiliates in accordance with guidelines established in the NAIC Accounting Purposes and Procedures Manual.

**Federal income taxes recoverable** - The Company did not maintain supporting records for its taxes in its Alabama home office in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**Claims Unpaid** - The Company did not maintain any documentation to support the unpaid claims liability at its home office in Birmingham, Alabama. This recommendation was made in the previous examination issued by the Alabama Department of Insurance.

In the preceding examination, it was recommended that the Company maintain all detailed information supporting the claims paid and claims payable reported in Schedule H of its future financial statements. This recommendation has been made again during the current examination.

During the review of the claims paid during 2001, the examiners requested policy level detail to support the amount of paid claims reported in the Underwriting and Investment Exhibit, Part 2B, columns 1 and 2, line 11. Of the \$318,729,674 in paid claims reported, the Company did not provide appropriate supporting detail (including policy level detail where applicable) for all amounts that composed \$26,974,165. The Company only provided general ledger activity to support this amount. The items in question were not related to specific policies and policy level detail was not applicable; however, the Company did not provide supporting documentation for the general ledger entries. This recommendation was made in the previous examination report.

The Company did not maintain any documentation to support the paid claims at its home office in Birmingham, Alabama. This recommendation was made in the previous examination report issued by the Alabama Department of Insurance.

## **COMMENTS AND RECOMMENDATIONS**

The following summary presents the comments and recommendations that are made in the current *Report of Examination*.

### **Committees – Page 5**

It is recommended that the Company only appoint directors to serve on committees of the Board of Directors as required by ALA. CODE § 10-2B-8.25 (1975), which states that:

"...a Board of Directors may create one or more committee and appoint members of the Board of Directors to serve on them. Each committee may have one or more members, who serve at the pleasure of the Board of Directors."

### **Holding Company – Data Ownership – Page 10**

It is recommended that the Company require that the data ownership agreement between United Healthcare Services and Unysis, and the data ownership agreement between Metra Health (now known as United HealthCare Insurance Company) and Integrated Systems Solutions Corporation be amended to name United Healthcare of Alabama as the sole owner of its data.

### **Holding Company and Affiliate Matters – Page 10**

It is recommended that management at the Company review all related party agreements before they become effective to insure that the terms and conditions of the agreement are fair and reasonable to the Company.

### **Transactions and Agreements with Affiliates – Page 17**

It is recommended that the Company maintain all approved service agreements with all affiliated companies that provide any service for the

Company as required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer. In no instance shall the Board of Directors of the HMO relinquish the right to dismiss the management contractor for failure to perform his required duties."

**It is recommended** that the Company submit for approval to the Commissioner of the Alabama Department of Insurance, the Tax Sharing Agreement, and the Subordinated Revolving Credit Agreement as required by ALA. CODE § 27-21A-2(c)(3) and (d)(1) (1975) and Alabama Department of Insurance Regulation Number 79 Section 13, which states "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer."

**It is recommended** that the Company halt all activity related to the Premium Allocation Agreement as it is in violation of ALA. CODE § 27-21A-6(c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's name..."

#### **Fidelity Bond and Other Insurance – Page 28**

**It is recommended** that the Company keep the records of its fidelity bond and other insurance coverage at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

#### **Territory – Page 30**

**It is recommended** that the Company properly report in its Annual Statements all territories where it is allowed to operate.

### **Policy Forms and Underwriting Practices – Page 32**

**It is recommended** that the Company properly maintain all of its reinstatement files to have access to those files whenever needed. These records should be kept and organized for examination purposes as required by Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions and affairs..."

**It is recommended** that the Company provide all documents requested by the examiners within ten days as required by Alabama Department of Insurance Regulation Number 118, Section 6, which requires: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

### **Advertising and Marketing – Page 33**

**It is recommended** that the Company not include any ambiguous or misleading information in any of its form letters, and not use any other names except for its corporate name that was approved by the Commissioner, in accordance with ALA. CODE § 27-21A-13 (d) (1975), which requires that

"No health maintenance organization unless licensed as an insurer may refer to itself as a licensed insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in this state."

and Alabama Department of Insurance Regulation Number 79 Section 12 states "No name other than that approved by the Commissioner may be used. The name of the HMO may not be changed without prior approval of the Commissioner. Any name which is misleading as to the purpose or type of organization or which is deceptively similar to the name of another licensed HMO shall not be used by the HMO."

**It is also recommended** that the Company not instruct its customers to send their premiums to any entities outside the state of Alabama, which is not in compliance with ALA. CODE § 27-21A-6 (c) (1975), which requires that

“Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization’s funds shall not deposit or invest such funds except in the organization’s corporate name...” ALA. CODE § 27-27-29 (1975) requires that “Every domestic insurer shall have, and maintain, its assets in this state...”

### **Claims Payment Practices – Page 35**

**It is recommended** that the Company keep all records pertaining to its claims at its headquarters or in a location approved by the Commissioner as required by ALA. CODE § 27-21A-16 (f) (1975), which states that:

"All records necessary for the complete examination of the health maintenance organization domiciled organization domiciled in this state shall be maintained in a location approved by the Commissioner."

**It is recommended** that the Company not delay the sending of claim checks after the paid date.

**It is recommended** that the Company not impose any limits on mental health benefit services that are not imposed on medical and surgical services in compliance with ALA. CODE § 27-54-4 (b) (1) (1975), which stipulates that:

"The group health benefit plan shall offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses"

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

### **Treatment of Members and Claimants – Page 35**

It is recommended that the Company properly include a requirement in its complaint handling procedures indicating that complaints received through the Department must be responded to within ten days in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

and Alabama Department of Insurance Bulletin dated January 31, 1963, which states:

"The Department of Insurance henceforth will take the position that an insurance company must answer both the policy holder and this Department within ten days after receipt of a departmental complaint."

### **Compliance With Agents' Licensing Requirements – Page 40**

It is noted that the Company paid commissions to agencies not licensed in the state of Alabama totaling \$2,451.92.

It is recommended that the Company keep the necessary detail on the commissions paid to its producers and comply with ALA. CODE § 27-7-35.1 (1975), which states:

- “(a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
- (b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
- (c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this chapter at the time of the sale, solicitation, or negotiation and was so licensed at that time.

- (d) An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate chapter 12 of this title.
- (e) Any insurer or producer violating this section shall be liable for a fine in an amount of up to three times the amount of the commission paid. The fine shall be levied and collected by the commissioner. Upon failure to pay the fine the commissioner may, in his or her discretion, revoke the license of the producer or the insurer's certificate of authority, or both."

**It is recommended** that the Company either maintain all producer records at its headquarters in the state of Alabama or obtain Commissioner authorization to move the records out of state. This should be done to comply with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

and ALA. CODE § 27-8-24 (c) (1975), which requires that:

"Upon termination of the appointment of an agent, or as soon thereafter as possible, and immediately upon completion of the insurer's investigation, the insurer shall file with the Commissioner a written statement of the facts relative to the termination and the date and cause thereof..."

### **Rate Filings – Page 43**

**It is recommended** that the Company properly maintain its records relating to the small group rate filings in accordance with Ala. Admin. Code 482-1-116 Section .05 (g) (2) (2002) which requires that: "Each small employer carrier shall file with the Commissioner annually on or before March 15, both of the following:

- a. An actuarial certification certifying that the carrier is in compliance with this regulation... A copy of the certification shall be retained by the small employer carrier at its principal place of business."

#### **Reinsurance – Page 44**

**It is recommended** that the Company submit its general liability and reinsurance policies to the Commissioner with each annual report in accordance with the Alabama Department of Insurance Regulation Number 79 Section 14.

**It is recommended** that the Company evaluate its exposure and potential need for additional reinsurance coverage due to issuing policies to its members with no stated maximum benefits.

**It is recommended** that the Company provide requested information in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states that "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner..."

#### **Accounts and Records – Page 46**

**It is recommended** that the Company require that its CPA firm make available for review all workpapers prepared in the conduct of their examination and any communication related to the audit between the CPA firm and the Company in accordance with the NAIC Annual Statement Instructions.

**It is recommended** that the Company provide all information requested by the examiners as required in Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

**It is recommended** that the Company not retain information outside the State of Alabama in accordance with the Alabama Department of Insurance Regulation Number 79 Section 15, which states:

"Removal of all, or a material part thereof, the records or assets of an Alabama domiciled HMO except pursuant to a plan of merger or consolidation approved by the Commissioner, or concealment of such records or assets, or material part thereof, from the Commissioner is prohibited. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets, or material part thereof, outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975."

**It is recommended** that the Company require its current opining CPA firm to follow-up on identified control and performance gaps to verify appropriate corrective action on all of the identified gaps and/or weaknesses.

#### **Bonds – Page 55**

**It is again recommended** that the Company value its bonds in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office and Alabama Department of Insurance Regulation Number 98. **It is further recommended** that bonds not valued in accordance with standards promulgated by the SVO be carried as non-admitted assets until such time as the Company has complied with said standards.

**It is recommended** that the Company keep the records of custodial agreements at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..." A similar recommendation was made in the previous examination report.

**It is recommended** that the Company properly complete and attach to each quarterly and annual statement a SVO certification which is required in the NAIC Annual Statement Instructions for 2001:

"There is to be completed and attached to each quarterly and annual statement of the Company a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion."

**It is recommended** that the Company use the scientific method to amortize bonds as required by SSAP No. 26, paragraph 6 which requires that:

"Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

**It is also recommended** that the Company not include the cost of accrued interest in the calculation of book value as required by the NAIC Annual Statement Instructions. -

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

#### Cash - Page 57

**It is recommended** that the Company include all balances in this line item both positive and negative in accordance with the NAIC Annual Statement Instructions for 2001.

**It is recommended** that the Company comply with ALA. CODE § 27-21A-6(c) (1975), which states:

"Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..."

**It is also recommended** that the Company comply with ALA. CODE § 27-27-29 (b) (1975), which states:

"Every domestic insurer shall have, and maintain, its assets in this state..."

**It is recommended** that the Company record all interest received from investments in the appropriate schedules in its Annual Statements.

**It is recommended** that the Company receive, from UnitedHealth Group Incorporated, the outstanding checks in electronic format and maintain a listing of outstanding checks in electronic format.

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

**It is recommended** that the Company keep the records of its investment transactions, including the preservation of outstanding check lists, at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

#### **Accident and health premiums due and unpaid – Page 59**

**It is recommended** that the Company maintain complete records supporting its premiums receivable at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall

have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs...”

**It is recommended** that the Company non-admit all receivables over ninety days in accordance with SSAP No. 6, paragraph 9.

**It is recommended** that the Company keep supporting documentation for the calculation of its allowance for doubtful accounts.

**Healthcare receivables – Page 60**

**It is recommended** that the Company charge a fair and reasonable amount of interest when loaning money to health care providers.

**Amounts recoverable from reinsurers – Page 60**

**It was noted** that United HealthCare of Alabama recorded a receivable at year-end 2001 and United HealthCare Insurance Company did not establish a payable for \$80,815 at year-end 2001.

**It is recommended** that the Company not establish receivables from affiliates if related liabilities are not established by affiliates.

**Amounts due from parent, subsidiaries, and affiliates – Page 60**

**It is recommended** that the Company record receivables and payables separately if amounts are due from or to different affiliates, in accordance with the guidelines established in the SSAP No. 64 of the NAIC Accounting Practices and Procedures Manual.

**Amounts receivable relating to uninsured accident and health plans – Page 61**

**It is recommended** that the Company not pay claims on behalf of United HealthCare Management Company without a formal agreement.

**It is recommended** that the Company not pay deductibles for its groups without a formal agreement.

**It is recommended** that the Company keep the records of its uninsured plans in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

#### **Receivable for securities – Page 62**

**It is recommended** that the Company only classify amounts as "Receivable for securities" when the asset meets the requirement of the NAIC Annual Statement Instructions for this line item.

#### **Claims unpaid – Page 63**

**It is recommended** that the Company's unpaid claim liability include claims that have not been paid as of the Annual Statement date in accordance with SSAP No. 55, paragraph 6 of the NAIC Accounting Practices and Procedures Manual.

**It is recommended** that the Company maintain all detailed information including claims files, canceled checks and cash disbursement transactions supporting each claim included in the claims liability recorded in the Underwriting and Investment Exhibit- Part 2A of its Annual Statements.

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

**It is recommended** that the claims detail provided to support the unpaid claims liability be consistent with the claims information in the Company's claims files.

**It is recommended** that the Company keep the records of its unpaid and paid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**It is recommended** that the Company maintain supporting documentation, including policy-level detail where applicable, to support each paid claim recorded in the Underwriting and Investment Exhibit- Part 2B of its Annual Statements.

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

#### **Accrued Medical Incentive Pool and Bonus Payments – Page 67**

**It is recommended** that the Company create a contract for the Medicare Primary Care Physicians (PCP) bonus program detailing the specifics and conditions of the program.

**It is recommended** that the Company maintain all documentation to support the amount of quarterly Medicare PCP bonus payments.

**It is recommended** that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

#### **Premiums Received in Advance – Page 68**

It is **recommended** that the Company comply with ALA. CODE § 27-2-23(b) (1975), which states "Every person being examined, its officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner or his examiners the accounts, records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination."

It is **recommended** that the Company comply with Alabama Department of Insurance Regulation Number 118, Section 6, which states "The insurer shall provide, within ten (10) working days, any records or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

#### **General expenses due or accrued – Page 69**

It is **recommended** that the Company record all expenses in the Annual Statement for the year in which they are incurred.

It is **again recommended** that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date.

#### **Commitments and Contingent Liabilities – Page 69**

It is **again recommended** that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date.

It is **recommended** that the Company provide any record or response requested in writing by the Alabama Department of Insurance within ten working days as required by Alabama Department of Insurance Regulation Number 118.

It is **recommended** that the Company keep all necessary records in an Alabama location that are required for the efficient examination of its financial condition and health care delivery system as required by Alabama Department of Insurance Regulation Number 79 Section 15.

**It is recommended** that the Company move its operations back to Alabama and maintain its principal place of business and home office in this state and keep therein complete records of its assets, transactions and affairs as required by Alabama Department of Insurance Regulation Number 79 Section 15.

**It is noted** that Alabama Department of Insurance Regulation Number 79 Section 15 also specifies that: "Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..." Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

**It is recommended** that the Company's books and records accurately reflect its legal expenses instead of those expenses being paid by affiliated entities.

Furthermore, **it is recommended** that the Company maintain documentation that when insuring risks, either directly or through affiliates, that those risks are insured with entities that are approved to write business in the appropriate jurisdictions of the United States.

**It is recommended** that the Company not pay legal expenses that should be covered by insurance policies purchased by or through UnitedHealth Services.

#### **Subsequent Events – Page 74**

**It is recommended** that the Company comply with the Alabama Department of Public Health Rule Number 420-5-6.11(2)(a), which requires that the Company's Medical Director have a physician's license in the State of Alabama.

#### **Compliance with previous recommendations – Page 75**

**It is again recommended** that the Company keep the records of its brokers' advices and approved custodial agreements at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health

maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**It is again recommended** that the Company non-admit all account balances ninety days past due in its future financial statements in accordance with the NAIC Accounting Practices and Procedures Manual.

**It is again recommended** that the Company maintain all detailed information supporting the premium receivable amount reported in its 2001 Annual Statement.

**It is again recommended** that the Company maintain complete records supporting the premium receivable amounts at its Alabama home office or in a location approved by the Commissioner in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79.

**It is again recommended** that the Company record receivables and payables separately if amounts are due from or to different affiliates, in accordance with the guidelines established in the SSAP No. 64 of the NAIC Accounting Practices and Procedures Manual.

**It is again recommended** that the Company keep the records of its unpaid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**It is again recommended** that the Company maintain all detailed information including claims files, canceled checks and cash disbursement transactions to support each claim included in the claims liability recorded in the Underwriting and Investment Exhibit- Part 2A of its Annual Statements.

**It is again recommended** that the Company maintain all policy level detail to support the paid claims reported in the Underwriting and Investment Exhibit-Part 2B of its Annual Statements.

**It is again recommended** that the Company keep the records of its paid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

**It is again recommended** that the Company keep the records of its bank account activity at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

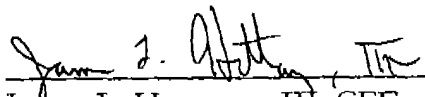
**It is again recommended** that the Company keep the records of its taxes at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

## CONCLUSION

The customary insurance examination procedures as recommended by the National Association of Insurance Commissioners have been followed to the extent appropriate and possible in connection with this examination.

In addition to the undersigned, Anne Ogle, Tisha Freeman, Douglas Moseley, and Shaun Sori, Examiners; and Joe Wallace, ASA, Consulting Actuarial Examiner, all representing the Alabama Department of Insurance, participated in this examination of United HealthCare of Alabama, Inc.

Respectfully submitted,

  
\_\_\_\_\_  
James L. Hattaway, III, CFE  
Examiner-in-Charge  
State of Alabama Department of Insurance

February 17, 2004

## **ADDENDUM**

The examiners provided the standard NAIC Representation Letter to the following officers/individuals representing United HealthCare of Alabama for their signature: T. David Lewis, President, Christina R. Palme-Krizak, Secretary, Robert W. Oberrender, Treasurer, Rhonda R. Bagby, Vice President – Finance, and Carolyn Callopy-Mora, Market Conduct Examination/Assessment Team Manager.

Without consultation with the examiners or disclosure to the examiners, the Company modified the representation letter to:

- 1.) Limit the time period covered by their representation to January 1, 2000 to December 31, 2001 instead of January 1, 2000 to August 13, 2003.
- 2.) Remove Christina R. Palme-Krizak, Robert W. Oberrender, and Carolyn Callopy-Mora from the representation letter.

**STATEMENT OF ASSETS, LIABILITIES, SURPLUS AND OTHER FUNDS**  
**For the Year Ended December 31, 2001**  
**AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED**  
**ANNUAL STATEMENTS**

| <b><u>ASSETS</u></b>   | <b><u>Assets</u></b>  | <b><u>Nonadmitted<br/>Assets</u></b> | <b><u>Net Admitted<br/>Assets</u></b> |
|--|-----------------------|--------------------------------------|---------------------------------------|
| Bonds  | \$ 102,513,521        |                                      | \$ 102,513,521                        |
| Cash and short-term investments                                    | 25,382,135            |                                      | 25,382,135                            |
| Receivable for securities  | 34,600                |                                      | 34,600                                |
| Accident and health premiums due and unpaid                        | 1,991,826             | 1,576,781                            | 415,045                               |
| Health care receivables  | 284,872               | 284,872                              |                                       |
| Amounts recoverable from reinsurers                                | 80,815                |                                      | 80,815                                |
| Investment income due and accrued                                  | 1,604,185             |                                      | 1,604,185                             |
| Amounts due from parent, subsidiaries and affiliates               | 222,516               |                                      | 222,516                               |
| Amounts receivable relating to uninsured accident and health plans | 262,414               | 12,390                               | 250,024                               |
| Federal and foreign income tax recoverable                         | 2,815,545             |                                      | 2,815,545                             |
| Other receivables  | 62,000                |                                      | 62,000                                |
| Prepays  | 266,344               | 266,344                              | -                                     |
| <b>TOTAL ASSETS</b>  | <b>\$ 135,520,773</b> | <b>\$ 2,140,387</b>                  | <b>\$ 133,380,386</b>                 |
| <br><b><u>LIABILITIES</u></b>                                      |                       |                                      |                                       |
|  | <b><u>Covered</u></b> | <b><u>Uncovered</u></b>              | <b><u>Total</u></b>                   |
| Claims unpaid  | \$ 43,022,567         | \$ 4,558,241                         | \$ 47,580,808                         |
| Accrued medical incentive pool and bonus payments                  | 35,000                |                                      | 35,000                                |
| Aggregate claim reserves   | 791,673               |                                      | 791,673                               |
| Premiums received in advance                                       | 19,445,321            |                                      | 19,445,321                            |
| General expenses due or accrued                                    | 661,688               |                                      | 661,688                               |
| Federal and foreign income tax payable                             | 5,549,060             |                                      | 5,549,060                             |
| Amounts withheld or retained by company                            | 83,458                |                                      | 83,458                                |
| Other payables   | 297,947               |                                      | 297,947                               |
| <b>TOTAL LIABILITIES</b>   |                       |                                      | <b>\$ 74,444,955</b>                  |
| <br><b><u>SURPLUS</u></b>  |                       |                                      |                                       |
| Common capital stock   | XXX                   | XXX                                  | \$ 101,978                            |
| Preferred capital stock  | XXX                   | XXX                                  | 20,000                                |
| Gross paid in and contributed surplus                              | XXX                   | XXX                                  | 17,561,870                            |
| Less 15,000 shares treasury stock at cost                          | XXX                   | XXX                                  | (56,250)                              |
| Unassigned funds (surplus)   | XXX                   | XXX                                  | 41,307,833                            |
| <b>Surplus as regards policyholders</b>                            |                       |                                      | <b>\$ 58,935,431</b>                  |
| <b>TOTAL LIABILITIES AND SURPLUS</b>                               |                       |                                      | <b>\$ 133,380,386</b>                 |

**STATEMENT OF REVENUE AND EXPENSES**  
**For the Year Ended December 31, 2001**  
**AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED**  
**ANNUAL STATEMENTS**

**REVENUES**

|  |                       |
|--|-----------------------|
| Net premium income   | \$ 394,789,266        |
| Aggregate write-ins for other health care related revenues | -                     |
| Total Revenues   | <u>\$ 394,789,266</u> |

**MEDICAL AND HOSPITAL**

|  |                       |
|--|-----------------------|
| Hospital/medical benefits                          | \$ 309,179,607        |
| Other professional services                        | 76,844                |
| Aggregate write-ins for other medical and hospital | (1,880,024)           |
| Incentive pool and withhold adjustments            | <u>39,455</u>         |
| Subtotal   | <u>\$ 307,415,882</u> |

**Less:**

|  |                       |
|--|-----------------------|
| Net reinsurance recoveries                       | \$ 1,140,116          |
| Total medical and hospital                       | 306,275,766           |
| Claims adjustment expenses                       | 13,806,765            |
| General administrative expenses                  | <u>30,160,737</u>     |
| Total underwriting deductions                    | <u>\$ 350,243,268</u> |
| Total underwriting gain or (loss)                | <u>\$ 44,545,998</u>  |
| Net investment income earned                     | \$ 6,106,498          |
| Net realized capital gains or (losses)           | <u>399,272</u>        |
| Net investment gains or (losses)                 | <u>\$ 6,505,770</u>   |
| Aggregate write-ins for other income or expenses | <u>\$ 14,916</u>      |

|  |                      |
|--|----------------------|
| Net income or (loss) before federal income taxes | \$ 51,066,684        |
| Federal and foreign income taxes incurred        | <u>18,299,513</u>    |
| Net income (loss)                                | <u>\$ 32,767,171</u> |

**STATEMENT OF NET WORTH**  
**For the Years Ended December 31, 1999, 2000 and 2001**  
**AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED**  
**ANNUAL STATEMENTS**

|  | <u>1999</u>          | <u>2000</u>          | <u>2001</u>          |
|--|----------------------|----------------------|----------------------|
| Net worth beginning of year                              | \$ 2,945,572         | \$ 13,468,027        | \$ 30,196,005        |
| Increase (decrease) in paid in surplus                   | -                    | 9,500,000            | -                    |
| Net income   | 5,830,930            | 6,906,008            | 32,767,171           |
| Change in nonadmitted assets                             | 4,691,522            | 321,970              | 2,796,134            |
| Change in surplus notes                                  |                      |                      | (1,000,000)          |
| Cumulative effect of changes in accounting principles    |                      |                      | 44,630               |
| Dividends to stockholders                                |                      |                      | (5,748,508)          |
| Aggregate write-ins for changes in other net worth items | 3                    | -                    | (120,000)            |
| Net worth end of year                                    | <u>\$ 13,468,027</u> | <u>\$ 30,196,005</u> | <u>\$ 58,935,432</u> |

Mr. Jack A. Wickens

Page 2

September 24, 2002

As part of your examination, the enclosed internal control and information systems questionnaire is required to be completed for review by our examiner. Please complete and return the questionnaire to this Department within 30 days, addressed to the attention of the Examiners' Division. The questions may be answered on the questionnaire itself or on a separate sheet if additional explanation is required. If possible, your CPA's workpapers and a representative of your CPA firm should be available the week of November 4, 2002, for review at your offices.

Invoices covering examination fees and related expenses will be submitted to the appropriate company official in accordance with standard Departmental policy. Payment of any examination charges so invoiced are due within two business days following presentation of the invoice.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard L. Ford".

Richard L. Ford, CFE, CIE  
Acting Deputy Commissioner and  
Chief Examiner

RLF:dk

Enclosures

cc: Jack M. Brown, CFE, CIE  
James L. Hattaway, CFE, Examiner-in-Charge  
LaShonda Moultrie, Analyst



DON SIEGELMAN  
GOVERNOR

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE  
201 MONROE STREET, SUITE 1700  
POST OFFICE BOX 303351  
MONTGOMERY, ALABAMA 36130-3351  
TELEPHONE: (334) 269-3550  
FACSIMILE: (334) 241-4192  
INTERNET: [www.aldoi.org](http://www.aldoi.org)

D. DAVID PARSONS  
COMMISSIONER  
ASSISTANT COMMISSIONER  
TREY GRANGER  
DEPUTY COMMISSIONER  
JAMES R. (JOHNNY) JOHNSON  
CHIEF EXAMINER  
RICHARD L. FORD  
STATE FIRE MARSHAL  
JOHN S. ROBISON  
GENERAL COUNSEL  
MICHAEL A. BOWNES  
RECEIVER  
DENISE B. AZAR  
LICENSING MANAGER  
JIMMY W. GUNN

September 24, 2002

Mr. Jack A. Wickens  
President  
United Healthcare of Alabama, Inc.  
3700 Colonnade Parkway  
Birmingham, AL 35243

**Re: Financial/Market Conduct Examination As Of December 31, 2001**

Dear Mr. Wickens:

This letter is to inform you of a financial/market conduct examination of your company called by the Alabama Department of Insurance and to authorize James L. Hattaway, CFE, Examiner, to conduct the examination. This authorization is pursuant to the instructions of Alabama Insurance Commissioner, D. David Parsons, and in compliance with the statutory requirements of the State of Alabama and resolutions adopted by the National Association of Insurance Commissioners. The NAIC has required as an accreditation standard that examination reports be issued within eighteen (18) months of the "as of" date of the examination. This is requiring us to begin the examinations earlier to meet this requirement.

Your examination is to commence on or about November 4, 2002, and will be conducted primarily in your offices. The expected duration of the examination is approximately six months. Preliminary planning of your examination will first begin in the offices of the Alabama Department of Insurance. The examiner will arrive in your offices on or after this date. You will be contacted by Mr. Hattaway regarding the exact arrival date at your offices.

The Alabama Insurance Department has adopted work policies and rules governing work hours, leave and unacceptable conduct including sexual harassment. If you have any question about our examiner's conduct at your offices, please contact me immediately.

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

## 1. Article Addressed to:

Mr. Jack A. Wickens  
President  
United Healthcare of Alabama Inc  
3700 Colonnade Parkway  
Birmingham, AL 35243

## 2. Article Number (Copy from service label)

7099 3400 0015 2327 6064

PS Form 3811, July 1999

Domestic Return Receipt

**COMPLETE THIS SECTION ON DELIVERY**

A. Received by (Please Print Clearly)

CMASON

B. Date of Delivery

09-26-02

C. Signature

X

CMASON

☐ Agent☐ Addressee

D. Is delivery address different from item 1?

☐ Yes

If YES, enter delivery address below:

☐ No

## 3. Service Type

☒ Certified Mail☐ Express Mail☐ Registered☒ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

## 4. Restricted Delivery? (Extra Fee)

☐ Yes

102595-00-M-0952



DON SIEGELMAN  
GOVERNOR

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE  
201 MONROE STREET, SUITE 1700  
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DENISE B. AZAR  
LICENSING MANAGER  
JIMMY W. GUNN

September 24, 2002

Mr. Glen Taylor  
Taylor-Walker & Associates, Inc.  
Actuarial Consulting Group  
P. O. Box 156  
40 North Main  
Midvale, UT 84047

Re: **Market Conduct/Financial Examination of United Healthcare of  
Alabama, Inc.**

Dear Mr. Taylor:

This letter is to request and authorize your participation in the examination of the above referenced company for the purpose of computing reserves and making other valuations in your usual manner.

The examination is scheduled to begin on or about November 4, 2002. The examination for this company is being conducted in the company's offices at 3700 Colonnade Parkway, Birmingham, AL 35243, and will cover the period of time ending December 31, 2001. The expected duration of the examination is approximately six months. The company's telephone number is (205) 977-6300.

The Examiner-in-Charge will be Mr. James L. Hattaway. Please contact him at the company after the beginning date to coordinate the scheduling of your portion of this examination.

If your schedule does not permit you to accept this assignment, please let me know so that other arrangements can be made.

Thank you for your assistance in this matter.

Sincerely,

Richard L. Ford, CFE, CIE  
Acting Deputy Commissioner and  
Chief Examiner

RLF:dk

cc: Jack M. Brown, CFE, CIE  
James L. Hattaway, Examiner-in-Charge  
LaShonda Moultrie, Analyst

EQUAL OPPORTUNITY EMPLOYER

**SENDER: COMPLETE THIS SECTION**

- Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

## 1. Article Addressed to:

Mr. Glen Taylor  
Taylor-Walker & Associates Inc  
Actuarial Consulting Group  
P O Box 156  
40 North Main  
Midvale UT 84047

**COMPLETE THIS SECTION ON DELIVERY**

A. Received by (Please Print Clearly) B. Date of Delivery

RR 9-30

C. Signature

X Glen Taylor ☐ Agent ☐ AddresseeD. Is delivery address different from item 1? ☐ YesIf YES, enter delivery address below: ☐ No

## 3. Service Type

☒ Certified Mail ☐ Express Mail  
☐ Registered ☒ Return Receipt for Merchandise  
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

## 2. Article Number (Copy from service label)

7099 3406 0615 2327 6019

PS Form 3811, July 1999

Domestic Return Receipt

102595-00-M-0852

11-6-02



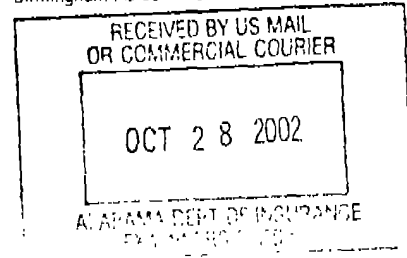
UnitedHealthcare

A UnitedHealth Group Company

October 24, 2002

UnitedHealthcare Alabama  
AL001-1001 P.O. Box 836037 Birmingham AL 35283-0637

Mr. Richard Ford, CFE, CIE  
Acting Deputy Commissioner & Chief Examiner  
Alabama Department of Insurance  
201 Monroe Street, Suite 1700  
P.O. Box 303351  
Montgomery, Alabama 36130-3351



RE: Financial/Market Conduct Examination As of December 31, 2001

Dear Mr. Ford:

We received your letter dated September 24, 2002. Enclosed please find the completed planning and information systems questionnaires. The responses to the planning questionnaire include references to attachments that are also enclosed.

Our Health Plan Accounting Department would also like to begin pulling claims data as soon as possible in order to avoid time delays during the audit. We would appreciate your auditors providing us the parameters such as date ranges, data fields, etc., as soon as possible so that we can begin extracting the data.

Please call me at 1-800-264-3639 ext 237 when you determine the date that we can expect to have your examiner on site at our Birmingham, Alabama, location. Let me know if you require additional information.

Sincerely,

Rhonda R. Bagby  
Vice President, Finance

Copies without attachments sent to:

Jack M. Brown, CFE, CIE, AL Department of Insurance  
James L. Hattaway, CFE, Examiner-in-Charge, AL Department of Insurance  
LaShonda Moultrie, Analyst, AL Department of Insurance

Copies with planning questionnaire responses (no IS questionnaire) sent to:

Charles C. Pitts, CEO, UnitedHealthcare of Alabama  
Jean Boord, UnitedHealthcare Compliance  
Paula Guthrie, UnitedHealthcare Compliance



UnitedHealthcare of Alabama Inc.  
Post Office 830637 Birmingham AL 35283-0637

August 20, 2003

James L. Hattaway, III  
Examiner-In-Charge  
Alabama Department of Insurance  
PO Box 303350  
Montgomery, AL 36130-3350

We are providing this letter in connection with your examination of the statutory financial statements of United HealthCare of Alabama, Inc. as of December 31, 2001, and for the period from January 1, 2000 to December 31, 2001. We are responsible for the preparation in the statutory financial statements of financial position, results of operations, and changes in statutory financial position in conformity with the accounting practices prescribed or permitted by the Alabama Department of Insurance.

Certain representations in this letter are described as being limited to those matters that are material. Solely for the purpose of preparing this letter, the term "material," when used in this letter, means any item or group of similar items involving potential amounts of more than \$500,000. These amounts are not intended to represent the materiality threshold for financial reporting and disclosure purposes. Notwithstanding this, an item is considered material, regardless of size, if it involves an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement.

We confirm, to the best of our knowledge and belief, the following representations made to you during the examination.

1. We have made available to you all:

Statutory financial records and related data; and

Minutes of meetings of stockholders, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared.

2. There has been no:

Fraud or other irregularities involving management or employees who have significant roles in the internal control structure;

Fraud or other irregularities involving other employees that have or may have a material effect on the statutory financial statements;

Fraud or other irregularities involving agents, MGA's, third party administrators, independent contractors, holding companies or other individuals or parties that have or may have a material effect on the statutory financial position of the Company; or

Communications from regulatory agencies concerning noncompliance with, or deficiencies in, statutory financial reporting practices. This includes those related to Medicare and Medicaid antifraud and abuse statutes.

3. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.

4. The financial statements are free of material and intentional immaterial misstatements.

5. The following have been properly recorded or disclosed in the statutory financial statements:

Any related party transactions and related amounts receivable or payable, including sales, purchases, loans, transfers, leasing arrangements, and guarantees.

All liabilities, both actual and contingent.

Guarantees whether written or oral, under which the company is contingently liable.

Capital Stock repurchase options or agreements on capital stock reserved for options, warrants, conversions, or other requirements.

Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances and line-of-credit or similar arrangements.

Significant estimates and material concentrations known to management that are required to be disclosed in accordance with SSAP No. 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures*.

Amount of credit risk and extent, nature, and terms of financial instruments with off-balance-sheet risk to be disclosed in accordance with SSAP No. 27.

Agreements to repurchase assets previously sold.

6. We confirm the completeness of the information provided regarding the identification of related parties.

7. There are no violations or possible violations of laws or regulations whose effects should be considered for disclosure in the statutory financial statements or as a basis for recording a loss contingency. This includes those related to Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid anti-Kickback Statutes, Limitations on Certain Physical Referrals (the Stark law), and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

8. Billings to third party payors comply in all material respects with diagnostic and procedure coding guidelines (for example ICD-9-CM and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (i.e. Food and Drug Administration), if required and properly rendered.

9. Contingent Liabilities:

There are no other liabilities or gain or loss contingencies that are required to be accrued or disclosed by SSAP No. 5.

There is no litigation against the Company that is considered material in relation to the statutory financial position of the Company. For purposes of this section, the company has excluded litigation for which the only amounts sought relate to benefits within the normal terms of coverage under contracts of insurance issued by the company, and which are otherwise considered in the actuarial determination of the company's unpaid claim reserves.

10. Adequate provision has been made for adjustments and losses in collection of receivables.

11. Provision has been made for estimated retroactive adjustments by third-party payors under reimbursement agreements.

12. The Company is in compliance with bond indentures or other debt instruments.

13. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Company are properly disclosed.

14. The Company has properly classified all assets as admitted or nonadmitted in accordance with SSAP No. 4.

15. The Company has free and clear title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged except as disclosed in the annual statement.

16. We have reviewed long-lived assets and certain identifiable intangibles whenever changes in circumstances have indicated that the carrying amount of these assets might not be recoverable and have recorded the adjustment in accordance with SSAP No. 5.

17. Deferred tax assets and liabilities as reported in the financial statements comply and have been valued in accordance with SSAP No. 10, *Income Taxes*.

18. Investments are appropriately recorded and valued as follows:

Bonds - are recorded and disclosed in accordance with SSAP No. 26 and interpretations thereof.

Short-term investments - are recorded and disclosed in accordance with SSAP No. 2 and interpretations thereof.

19. Accident and Health Premiums Due and Unpaid - Premiums are recognized and reported in accordance with SSAP No. 54. Uncollected premiums are reported in accordance with SSAP No. 6.

20. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to diagnosis- related group (DRG) assignments.

21. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available.

22. Cost Reports filed with third parties:

All required Medicare, Medicaid, and similar reports have been properly filed.

Management is responsible for accuracy and propriety of all cost records filed.

All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.

The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

All items required to be disclosed, including disputed costs that are being claimed to establish a basis for subsequent appeal, have been fully disclosed in the cost report.

Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations.

23. The Company's actuary has certified to the propriety of the basis and amounts at which the claim reserves and all actuarial liabilities are stated at December 31, 2001.

24. The Company has recorded individual and group accident and health reserves in accordance with SSAP No. 54.

25. The Company's liabilities for unpaid claims and claim adjustment expenses are based on and recorded at management's best estimate in accordance with SSAP No. 55.

26. Utilization Data has been properly determined and included in the statutory financial statement.

27. Covered liabilities are properly stated in the statutory financial statement and are determined as health care services covered through "hold harmless" clauses in the provider contracts which

state that providers will not bill enrollees even though the provider has not been paid by the HMO.

28. The Company is in compliance with contractual agreements, grants, and donor restrictions.

29. There were no material commitments for construction or acquisition of property, plant and equipment, or to acquire other noncurrent assets, such as investments or intangibles.

30. Intentionally omitted.

31. We have complied with all aspects of contractual agreements that would have a material effect on the statutory financial statement in the event of noncompliance.

32. There are no material transactions that have not been properly recorded in the accounting records underlying the statutory financial statements.

33. All required returns and statutory reporting requirements have been filed on a timely basis with the appropriate regulatory bodies.

34. All material reinsurance transactions have been recorded and disclosed in accordance with SSAP No. 61.

35. The Company has properly disclosed and recorded all changes in accounting principles in accordance with SSAP No. 3.

36. The Company has recorded and disclosed subsequent events in accordance with SSAP No. 9.

37. Intentionally omitted.

38. The Company is not aware of the employment of or a business relationship with a "prohibited person" as defined in The Violent Crime Control and Law Enforcement Act of 1994: United States Code, Section 1033 (e)(1)(A).

39. Intentionally omitted.

40. Intentionally omitted.

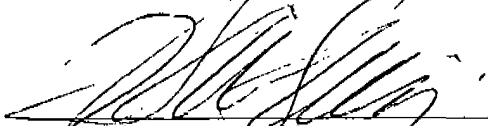
41. Intentionally omitted.

42. The Company has recorded and disclosed defined benefit plans and defined contribution plans in accordance with SSAP No. 8.

43. The Company has recorded and disclosed postretirement benefits other than pensions in accordance with SSAP No. 14.

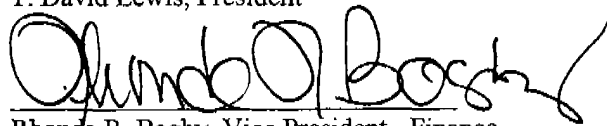
We understand that your examination was made in accordance with standards established by the Alabama Department of Insurance, and procedures established by the *National Association of Insurance Commissioners*, and accordingly included such tests of the accounting records and such other procedures as considered necessary under the circumstances.

United HealthCare of Alabama, Inc.



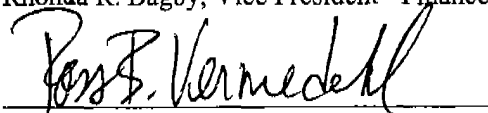
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T. David Lewis, President



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Rhonda R. Bagby, Vice President - Finance



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Ross B. Vermedahl, Director of UnitedHealthcare Finance



BOB RILEY  
GOVERNOR

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE  
201 MONROE STREET, SUITE 1700  
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INTERNET: [www.aldoi.org](http://www.aldoi.org)

WALTER A. BELL  
COMMISSIONER  
DEPUTY COMMISSIONER  
D. DAVID PARSONS  
JAMES R. (JOHNNY) JOHNSON  
CHIEF EXAMINER  
RICHARD L. FORD  
STATE FIRE MARSHAL  
JOHN S. ROBISON  
GENERAL COUNSEL  
MICHAEL A. BOWNES  
RECEIVER  
DENISE B. AZAR  
PRODUCER LICENSING MANAGER  
JIMMY W. GUNN

September 9, 2003

**CERTIFIED MAIL**  
**RETURN RECEIPT REQUESTED**

Mr. Jack A. Wickens  
President  
United Healthcare of Alabama, Inc.  
3700 Colonnade Parkway  
Birmingham, AL 35243

**RE: Financial/Market Conduct Examination as of December 31, 2001**

Dear Mr. Wickens:

Enclosed is a copy of the Report of Examination of the above-cited company as of December 31, 2001. In the event that you have any objections to this report, please advise this Department in writing within twenty (20) days, and a hearing will be scheduled, at which time you may present your arguments regarding any objections.

Unless we hear from you within the above-stated time, the report will be filed as a public document. Once filed, no annual or quarterly statements, or other material reflecting the statutory financial condition of the company may be filed with or accepted by this Department if those statements conflict with any basis of calculation to establish the value of any asset, liability, or capital account in the report.

Sincerely,

Richard L. Ford, CFE, CIE  
Chief Examiner

RLF:dk

Enclosure

cc: Jack M. Brown, CFE, CIE  
Jim Hattaway, CFE  
LaShonda Moultrie  
Taylor-Walker and Associates, Inc.

**PUBLIC REPORT OF THE MARKET CONDUCT EXAMINATION  
OF THE CLAIMS PRACTICES OF THE**

**UNITED HEALTHCARE INSURANCE COMPANY  
NAIC # 79413 CDI # 2140-2**

**AS OF DECEMBER 30, 2002**

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE  
MARKET CONDUCT DIVISION  
FIELD CLAIMS BUREAU**

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**CALIFORNIA DEPARTMENT OF INSURANCE**

Consumer Services and Market Conduct Branch  
Field Claims Bureau, 11th Floor  
Ronald Reagan State Office Building  
300 South Spring Street  
Los Angeles, CA 90013



June 9, 2003

The Honorable John Garamendi  
Insurance Commissioner  
State of California  
45 Fremont Street  
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

**United Healthcare Insurance Company**

**NAIC #79413**

Hereinafter referred to as the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938.

## SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Company during the period January 1, 2002 through December 30, 2002. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of fair claims settlement practices.
2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted at the offices of the California Department of Insurance in Los Angeles, California.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

### **CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS**

The examiners reviewed files drawn from the category of Closed Claims for the period January 1, 2002 through December 30, 2002, commonly referred to as the “review period”. The examiners reviewed 68 claims files. The examiners cited zero claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

| <b>United Healthcare Insurance Company</b> |                                     |                 |                  |
|--|-------------------------------------|-----------------|------------------|
| <b>CATEGORY</b>                            | <b>CLAIMS FOR<br/>REVIEW PERIOD</b> | <b>REVIEWED</b> | <b>CITATIONS</b> |
| Group Hospital Indemnity                   | 42,671                              | 68              | 0                |
| <b>TOTALS</b>                              | 42,671                              | 68              | 0                |

**SUMMARY OF CRITICISMS, INSURER  
COMPLIANCE ACTIONS AND TOTAL RECOVERIES**

There were no citations alleged or criticisms of insurer practices made within the scope of this report. There were no recoveries discovered within the scope of this report.

**MARKET CONDUCT EXAMINATION REPORT**  
**AS OF DECEMBER 31, 2002**

---

**United HealthCare of Colorado, Inc.**  
**8051 East Maplewood Avenue, Suite 300**  
**Greenwood Village, Colorado 80111**

---

**NAIC Group Code 0707**  
**NAIC Company Code 95090**

**EXAMINATION PERFORMED BY**  
**DIVISION OF INSURANCE STAFF**  
**COLORADO DEPARTMENT OF REGULATORY AGENCIES**  
**STATE OF COLORADO**

**United HealthCare of Colorado, Inc.  
8051 East Maplewood Avenue, Suite 300  
Greenwood Village, Colorado 80111**

**LIMITED MARKET CONDUCT  
EXAMINATION REPORT  
as of  
December 31, 2002**

**Examination Performed by  
Jeffory A. Olson, CIE, AIRC, ALHC  
David M. Tucker, AIE, FLMI, ACS  
Maggie Caouette  
Amy Gabert  
Kit Tucker**

**State Market Conduct Examiners**

October 9, 2003

The Honorable Doug Dean  
Commissioner of Insurance  
State of Colorado  
1560 Broadway, Suite 850  
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of United HealthCare of Colorado, Inc. (the Company) was conducted pursuant to Section 10-16-416, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its Denver office located at 8051 East Maplewood Avenue, Suite 300, Greenwood Village, Colorado, 80111 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory Olson, CIE, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Maggie Caouette

Amy Gabert

Kit Tucker

**MARKET CONDUCT  
EXAMINATION REPORT  
OF  
UNITED HEALTHCARE OF COLORADO, INC.**

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**COMPANY PROFILE**

United Healthcare of Colorado, Inc. (the "Company") was incorporated under the laws of the State of Colorado as a for-profit corporation on February 24, 1986, under the name "MetLife HealthCare Network of Colorado, Inc." On March 20, 1986, the Company was granted a certificate of authority by the Colorado Division of Insurance to operate as a health maintenance organization (HMO). On July 11, 1995, the Company changed its name to "MetraHealth Care Plan of Colorado, Inc."

The Company became affiliated with UnitedHealth Group Incorporated, (formerly known as United HealthCare Corporation and consistently referred to as "United") after United purchased 100% of The MetraHealth Companies, Inc. on October 2, 1995. At the time of the acquisition of The MetraHealth Companies, Inc. by United, the Company was a wholly owned subsidiary of the MetraHealth Care Management Corporation. The Colorado Division of Insurance approved the acquisition on September 1, 1995. On May 1, 1996, the Company's name was changed to "United HealthCare of Colorado, Inc."

Today, United HealthCare of Colorado, Inc. (NAIC Company Code: 95090; NAIC Group Code: 0707) is a wholly owned subsidiary of UnitedHealthcare, Inc. ("Uhc"), a Delaware corporation. Uhc is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a Minnesota corporation. UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated.

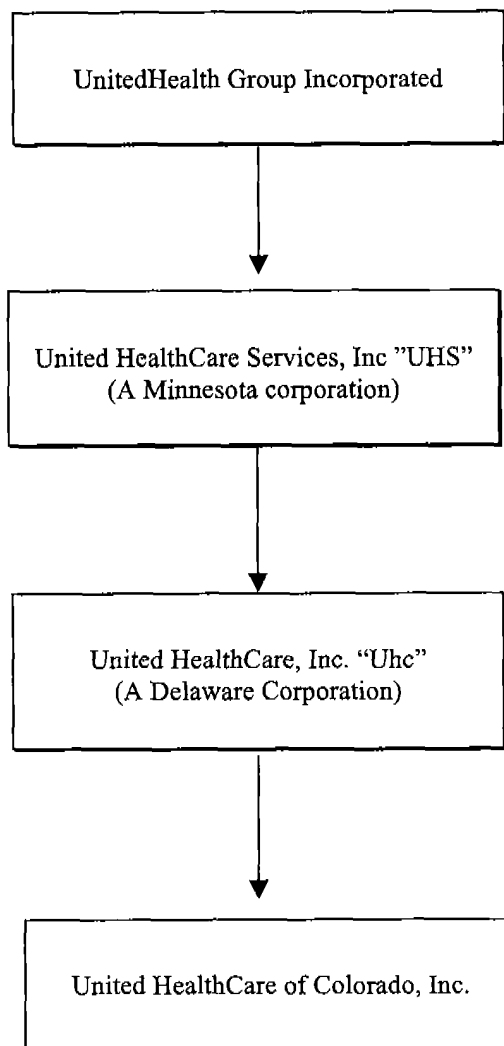
The Company, a for-profit HMO, offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers in the state of Colorado. The Company has entered into contracts with physicians, hospitals and other health care providers pursuant to which such providers deliver medical care to enrollees primarily on a modified fee-for-service basis.

United HealthCare, Inc. does not offer products on the individual level.

The following organizational chart shows the structure of United HealthCare of Colorado, Inc.

STRUCTURE AS OF DECEMBER 31, 2002

The following organizational chart depicts the Company's relationship within the corporate structure as of December 31, 2002.



**Market Conduct Examination  
Company Profile**

---

**United HealthCare of Colorado, Inc.**

Service Area

The Company is licensed to provide services in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Denver, Douglas, El Paso, Jefferson, Larimer, Lincoln, Otero, Park, Pueblo, Teller, and Weld counties in Colorado.

Enrollment As of 12-31-02: 71,436

Small Group: 35,035

Large Group: 36,401

Total Written Premium as of 12-31-02: \$ 206,949,129

Small Group Written Premium\*\*: \$ 98,566,370

Large Group Written Premium\*\*: \$ 107,286,863

Market Share (all Colorado HMO's): 6.55%

\*\* As provided by the Company.

## **PURPOSE AND SCOPE OF EXAMINATION**

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of United HealthCare of Colorado, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to Health Maintenance Organizations (HMO's). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The examination included review of the following:

- Company Operations/Management;
- Contract Forms;
- Rating;
- Applications/Renewals;
- Cancellations/Non-renewals/Declinations;
- Claims Handling; and
- Utilization Review.

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance reform laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization.

An error tolerance level of plus or minus ten dollars (\$10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar (\$0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar (\$0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

**EXAMINERS' METHODOLOGY**

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations. For this examination, special emphasis was given to small group reform, and the laws and regulations as shown in Exhibit 1.

During the exam, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although United HealthCare Insurance Company and United HealthCare of Colorado, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

**Exhibit 1**

| <b>Law/Regulation</b>       | <b>Concerning</b>   |
|-----------------------------|---|
| Section 10-1-101-10-1-130   | General Provisions  |
| Section 10-3-1101-10-3-1104 | Unfair Competition - Deceptive Practices  |
| Section 10-8-601-10-8-605   | Small Employer Health Insurance Availability Program Act  |
| Section 10-16-101-10-16-121 | Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions                     |
| Section 10-16-201-10-16-219 | Sickness and Accident Insurance   |
| Section 10-16-401-10-16-427 | Health Maintenance Organizations  |
| Section 10-16-701-10-16-708 | Consumer Protection Standards Act for the Operation of Managed Care Plans                                     |
| Regulation 1-1-4            | Maintenance of Offices in this State  |
| Regulation 1-1-7 (Revised)  | Market Conduct Record Retention   |
| Regulation 1-1-8            | Penalties and Timelines Concerning Division Inquires and Document Requests                                    |
| Regulation 4-2-5            | Hospital Definition   |
| Regulation 4-2-11           | Individual and Group Health Insurance Rate Filings  |
| Regulation 4-2-15           | Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers |
| Regulation 4-2-16           | Women's Access to Obstetricians and Gynecologists under Managed Care Plans                                    |
| Regulation 4-2-17           | Prompt Investigation of Health Plan Claims Involving Utilization Review                                       |
| Regulation 4-2-18           | Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions             |
| Regulation 4-2-21           | External Review of Benefit Denials of Health Coverage Plans   |
| Regulation 4-6-5,           | Implementation of Basic and Standard Health Benefit Plans   |

**Market Conduct Examination  
Examiners' Methodology**

---

**United HealthCare of Colorado, Inc.**

|                  |  |
|------------------|--|
| (Amended)        |  |
| Regulation 4-6-7 | Concerning Premium Rate Setting for Small Group Health Plans               |
| Regulation 4-6-8 | Concerning Small Employer Health Plans                                     |
| Regulation 4-6-9 | Conversion Coverage  |
| Regulation 4-7-1 | Health Maintenance Organizations   |
| Regulation 4-7-2 | Health Maintenance Organization Benefit Contracts and Services in Colorado |

**Company Operations/Management**

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

**Audits and Examinations**

The Company was the subject of a previous market conduct exam in 1998 and 1999, which covered the period January 1, 1997 through January 31, 1998. The Company also underwent a financial audit by the Colorado Division of Insurance in 1999, which covered the period of 1994 through 1998.

**Contract Forms**

The examiners reviewed the following forms:

- The Company's Basic and Standard HMO Plans, Co-payment Schedules, Evidences of Coverage and Schedule of Benefits;
- The Company's most commonly sold HMO group contracts marketed to small employers and business groups of one;
- The Company's HMO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2002 and December 31, 2002.

**Rating**

The examiners reviewed the premium rates charged in the samples of the files selected in the Underwriting (new applications and renewals) section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

**Applications**

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group new application files; and
- Fifty (50) renewed small group files.

**Cancellations/Non-Renewals/Declinations**

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group cancellation/non-renewal files; and
- The entire population of thirty-four (34) declined small group files.

**Claims**

Utilizing ACL™ software, the examiners selected samples of 100 paid and 100 denied small group HMO claims that were received during the period of January 1, 2002 through December 31, 2002. These claims were reviewed for the Company's overall claims handling practices and to determine accuracy of processing. It was determined that a sample size of 100 claims was appropriate in both of the above samples.

In order to determine the Company's compliance with Colorado's prompt payment of claims law, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days; and
- 100 non-electronic claims paid or denied beyond forty-five (45) days.

In addition, the examiners identified 289 claims out of a population of 64,501 denied and 4,527 claims out of a population of 380,951 paid small and large group claims that were not paid, or settled within ninety (90) days after receipt. These claims were reviewed to determine if they had been delayed due to fraud, and if not, if interest and penalties had been paid.

**Utilization Review**

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed the entire population of twenty-one (21) first level appeal files, the entire population of five (5) second level appeal files, and the entire population of one (1) external review file. A sample of fifty (50) utilization review reconsiderations out of a population of sixty-six (66) was also requested and reviewed. However, it was later determined that all but one of the fifty (50) files were not actually reconsiderations. Due to this information not being identified until near the end of the exam, and therefore lack of time to research and review possible other reconsiderations, utilization review reconsiderations are being omitted from this exam.

In addition, the examiners selected a sample of fifty (50) utilization review (UR) denial decision files from total populations of 1,096 and selected a sample of fifty (50) UR certification decisions from a total population of 2,633. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

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**EXAMINATION REPORT SUMMARY**

The examination resulted in a total of thirty-seven (37) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

**Operations/Management:** The examiners identified one (1) areas of concern in their review of the Company's operations/management.

1. Failure to correctly and completely list all applicable forms in the "Colorado Annual Report of Health Coverage Forms".

**Contract Forms:** The examiners identified thirteen (13) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

1. Failure of the Company's forms to allow for coverage of otherwise eligible dependents who do not reside within the service area.
  2. Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.
  3. Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.
  4. Failure of the Company's Standard Health Benefit Plan forms to exclude copayments for physician ordered lab and x-ray services.
  5. Failure of the Company's forms to provide durable medical equipment benefits in accordance with the law.
  6. Failure of the Company's forms to include the provision of complaint forms to enrollees in its complaint procedures.
  7. Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years as required by law.
  8. Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. *(This was prior issue E10 in the findings of the 1999 final examination report).*
  9. Failure of the Company's forms to contain a correct definition of a disabled dependent.
  10. Failure of the Company's forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law.
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11. Failure of the Company's forms to provide accurate information concerning premium rate setting.
12. Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.
13. Failure of the Company's forms to provide correct information regarding changes to premium rates.

**Rating:** The examiners identified one (1) area of concern in their review of small group rates used between January 1, 2002 and December 31, 2002.

1. Failure to include required information concerning the choice of either the age-banded or the composite rates.

**Applications:** The examiners identified five (5) areas of concern in their review of small group contracts issued between January 1, 2002 and December 31, 2002.

1. Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents.
2. Failure, in some instances, to include the required Basic and Standard plan disclosure in small group application materials.
3. Failure to obtain the required employer provided listing of eligible dependents.
4. Failure, in some instances, to include the small group disclosure requirements in new application materials. *(This was prior issue G3 in the findings of the 1999 final examination report.)*
5. Failure, in some instances, to notify the Commissioner of Insurance and policyholders prior to the discontinuation of small employer group health benefit plans.

**Cancellations/Non-Renewals/Declinations:** There were four (4) areas of concern identified during the review of the small group and individual cancellation/non-renewal/declination files.

1. Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied. *(This was prior issue H2 in the findings of the 1999 final examination report.)*
  2. Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law.
  3. Failure to examine all applicable tax returns when determining eligibility of business groups of one.
  4. Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups.
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**Claims:** The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company.

1. Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges.
2. Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.
3. Failure, in some instances, to pay interest and/or penalties on claims that were not paid, denied, or settled within the time periods required by Colorado insurance law.
4. Failure, in some instances, to process claims accurately.

**Utilization Review:** The examiners identified nine (9) areas of concern in their review of the Company's Utilization Review procedures.

1. Failure, in some instances, to make Utilization Review determinations and provide required notifications within the timeframes allowed under Colorado insurance law.
2. Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals.
3. Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days.
4. Failure, in some instances, to include all required components in First Level appeal determination letters.
5. Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination.
6. Failure, in some instances, to notify member fifteen (15) days in advance of the hearing date for second level appeals.
7. Failure, in some instances, to ensure that second level appeal panels include a majority of health care professionals with appropriate expertise to review the case.
8. Failure to include all the required elements in written notifications of second level appeal rights.
9. Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determinations.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at [www.dora.state.co.us/insurance](http://www.dora.state.co.us/insurance) or by contacting the Colorado Division of Insurance.

**MARKET CONDUCT EXAMINATION REPORT**

**FACTUAL FINDINGS**

**UNITED HEALTHCARE OF COLORADO, INC.**

**COMPANY OPERATIONS/MANAGEMENT**  
**FINDINGS**

**Issue A1: Failure to correctly and completely list all applicable forms in the "Colorado Annual Report of Health Coverage Forms".**

Section 10-16-107.2, C.R.S., Filing of health policies, states:

- (1) All sickness and accident insurers, *health maintenance organizations*, and nonprofit hospital and health service organizations authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.* Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.  
[Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law, in that its "Colorado Annual Report of Health Coverage Forms" for the year 2002:

1. Lists forms not in use during the 2002 calendar year. The filing lists forms with a 2003 effective date, but does not list the versions of these forms that were actually in use during 2002 calendar year. The Company's filing states:

| form #             | title                              | effective date of use |
|--------------------|------------------------------------|-----------------------|
| RXDC.H.02.CO       | Outpatient Prescription Drug Rider | 1/1/2003              |
| BASCHCCO.01        | CO Basic Health Benefit Plan       | 1/1/2003              |
| STDCHCCO.01        | CO Standard Health Benefit Plan    | 1/1/2003              |
| PolicyStdBas.01.CO | CO Basic and Standard Group Policy | 1/1/2003              |
| BASCONVCHC.01      | CO Conversion Policy-Basic Plan    | 1/1/2003              |
| STDCONVCHC.01      | CO Conversion Policy-Standard Plan | 1/1/2003              |

2. Fails to completely disclose all forms in use for the 2002 calendar year. The filing lists forms in use for part of 2002, but does not list the forms in use prior to the listed effective dates. The Company's filing states:

| form #         | title   | effective date of use |
|----------------|---|-----------------------|
| 380-1474 1/02  | Employee Enrollment                           | 4/15/2002             |
| 380-1475 1/02  | Employer Application (Groups with 100+ lives) | 4/15/2002             |
| 380-1476 1/02  | Employee Long Form Enrollment                 | 4/15/2002             |
| 380-1477 10/02 | Small Group Employer Application              | 11/6/2002             |

[Emphases added.]

**Market Conduct Examination  
Company Operations/Management**

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**United HealthCare of Colorado, Inc.**

Form

Date

Colorado Annual Report of Health Coverage Forms

December 2002

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**Recommendation No. 2:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to correctly and completely list all applicable forms in its "Colorado Annual Report of Health Coverage Forms" as required by Colorado insurance law.

**UNDERWRITING**  
**CONTRACT FORM**  
**FINDINGS**

**Issue E1: Failure of the Company's forms to allow for coverage of otherwise eligible dependents who do not reside within the service area.**

Section 10-16-102, C.R.S., Definitions, states:

- (14) *"Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent [emphases added], and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.*

Section 10-16-104, C.R.S., Dependent children, states:

- (6) (b) No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that the child:
- (I) *Does not live in the home of the parent applying for the policy; or*
  - (II) *Does not live in the insurer's service area, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer's service area; or ... [Emphases added]*

It appears that the Company's forms are not in compliance with Colorado insurance law in that they require a student dependent to reside within the Service Area to be eligible for coverage. Colorado law does not require a dependent child to reside within the Service Area of the HMO.

The Company's forms state:

Section 10: Glossary of Defined Terms

"To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or reside with the Subscriber who works within the Service Area."

Section 8: When Coverage Ends

- 1) "Your coverage ends on the [date][last day of the calendar month in which] you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. (This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order.) The Subscriber or the Enrolling Group must notify us if you move from the Service Area."

Forms

BASCHCCO.01  
STDCHCCO.01  
CHOICECO.01  
SELECTCO.01  
BASCONVCHC.01  
STDCONVCHC.01

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**Recommendation No. 2:**

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of Sections 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all of its affected forms to reflect the correct eligibility requirements for dependents as required by Colorado insurance law.

**Issue E2: Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.**

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Rules

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

35. What Treatments and Conditions are Excluded under this Policy?

Standard exclusions, including benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic care; custodial care; *dental care except for accidents* [emphasis added] and anesthesia for dependent children as required by law...

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for dental care following an accidental injury are more restrictive than required by law. The Company's 2002 Choice HMO Standard and Basic Health Plan certificate of coverage forms limit benefits to treatment of a sound, natural tooth that is certified by the dentist or physician as a virgin or unrestored tooth.

2002 Choice HMO Standard and Basic Health Benefit Plan Certificate of Coverage, states:

**4. Dental Services – Accident only**

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- *A virgin or unrestored tooth* [emphasis added], or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

| <u>Forms</u>  | <u>Date</u> |
|---------------|-------------|
| BASCHCCO.01   | 1/1/2002    |
| STDCHCCO.01   | 1/1/2002    |
| BASCONVCHC.01 | 1/1/2002    |
| STDCONVCHC.01 | 1/1/2002    |

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**Recommendation No. 3:**

Within thirty (30) days the Company should provide documentation demonstrating why its forms should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all of its affected forms to modify the restrictions on dental coverage related to accidents to ensure compliance with Colorado insurance law.

**Issue E3: Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.**

Regulation 4-2-8, amended effective February 1, 2001, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated pursuant to 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which *shall state clearly and completely the criteria for and extent of coverage for home health services and hospice care ...* [Emphasis added.]

Section 5. Requirements for Hospice Care

C. Benefits for Hospice Care Services.

- (3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:
  - (a) Bereavement support services for the family of the deceased person during the *twelve month period following death* [emphasis added], and in no event shall this maximum benefit be less than \$1150.
  - (b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;
  - (c) *Medical supplies;*
  - (d) *Drugs and biologicals;*

- (e) *Prosthesis and orthopedic appliances;*
- (f) *Oxygen and respiratory supplies;*
- (g) *Diagnostic testing;*
- (h) *Rental or purchase of durable equipment;*
- (i) *Transportation;*
- (j) *Physicians services;*
- (k) *Therapies including physical, occupational and speech; and*
- (l) *Nutritional counseling by a nutritionist or dietitian. [Emphases added.]*

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

**III. Rules**

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

**STANDARD AND BASIC HEALTH BENEFIT PLAN  
POLICY REQUIREMENTS FOR THE STATE OF COLORADO**

Colorado Division of Insurance  
January 1, 2002

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard health Benefit Plan."

|                                  |  |
|----------------------------------|--|
|                                  | <b>BASIC HMO PLAN</b>  |
|                                  | <b>IN-NETWORK ONLY</b><br>(out-of-network care is not covered except as noted) |
| 26. HOSPICE CARE <sup>22a.</sup> | \$50 copay inpatient per diem<br>\$20 copay home hospice per diem              |

|                                  |  |
|----------------------------------|--|
|                                  | <b>STANDARD HMO PLAN</b>   |
|                                  | <b>IN-NETWORK ONLY</b><br>(out-of-network care is not covered except as noted) |
| 26. HOSPICE CARE <sup>22a.</sup> | No copay (100% covered)  |

- 22a. Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Regulation 4-2-8.

It appears that the Company's forms are not in compliance with Colorado insurance law in that they do not provide a complete and accurate description of Hospice Care benefits. The Company's 2002 Choice Standard and Basic Health Benefit Plan certificate of coverage forms do not indicate that the following items are covered:

- Medical supplies;
- Drugs and biologicals;
- Prosthesis and orthopedic appliances;
- Oxygen and respiratory supplies;
- Diagnostic testing;
- Transportation;
- Physical, occupational and speech therapies;
- Nutritional counseling;
- Rental or purchase of durable equipment; and
- Physician services.

Additionally, the limitation of bereavement support services to the three month period following death appears to be more restrictive than that of Colorado insurance law.

The Company's 2002 Choice HMO Standard and Basic Health Benefit Plan Certificate of Coverage, states:

### Hospice Care

#### State Mandate

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.

Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members, the Covered Person's primary caregiver and for individuals with significant personal ties to the Covered Person. Benefits are available when hospice care is received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment. Hospice care includes intermittent non-routine inpatient respite care on a short-term basis.

Benefits are limited to three benefit periods of three months per benefit period during the entire period of time you are covered under the Policy. *Benefits for bereavement support services are limited to \$1,150 during the three month period following death.* [Emphasis added.]

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

| <u>Forms</u>  | <u>Date</u> |
|---------------|-------------|
| BASCHCCO.01   | 1/1/2002    |
| STDCHCCO.01   | 1/1/2002    |
| BASCONVCHC.01 | 1/1/2002    |
| STDCONVCHC.01 | 1/1/2002    |

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### Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-8 and 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct Hospice Care benefits as required by Colorado insurance law.

**Issue E4: Failure of the Company's Standard Health Benefit Plan forms to exclude copayments for physician ordered lab and x-ray services.**

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

III. Rules

- B. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN  
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance  
January 1, 2002

- III. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

|                                      |   |
|--------------------------------------|---|
|                                      | STANDARD HMO PLAN   |
|                                      | IN-NETWORK ONLY<br>(out-of-network care is not covered except as noted) |
| 14. LABORATORY & X-RAY <sup>11</sup> | No copay for physician-ordered services.                                |

11. Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, Section 10-16-104(4), C.R.S.

It appears that the Company is not in compliance with Colorado insurance law in that its Choice HMO Standard Health Benefit Plan forms do not indicate that no copay is required for physician ordered Laboratory and X-Ray services. It appears that an additional copayment would be charged to the member for diagnostic or therapeutic services received at a hospital or ancillary facility even if they were ordered by a physician. The Company's 2002 Choice HMO Standard Health Benefit Plan states:

**16. Outpatient Surgery, Diagnostic and Therapeutic Services**

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Surgery and related services.
- Lab and radiology / X-ray.
- Mammography testing not otherwise described as Covered under Physician Office Services below.
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

**Your Copayment Amount**  
% Copayments are based on  
a percent of Eligible Expenses

**Does Copayment  
Help Meet  
OOPM\*?**

\$50 per visit for outpatient surgery. *\$15 per visit for diagnostic and therapeutic services.* [Emphasis added].

Yes

Forms

Date

STDCHCCO.01  
STDCONVCHC.01

1/1/2002  
1/1/2002

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**Recommendation No. 5:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include a correct description of the copay requirements for lab and x-ray services in the Standard Health Benefit Plans as required by Colorado insurance law.

**Issue E5: Failure of the Company's forms to provide durable medical equipment benefits in accordance with Colorado insurance law.**

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

14. Prosthetic devices.

- (d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.
- (e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.
- (f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Rules

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

**STANDARD AND BASIC HEALTH BENEFIT PLAN  
POLICY REQUIREMENTS FOR THE STATE OF COLORADO**

Colorado Division of Insurance  
January 1, 2002

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- III. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

|   |  |
|---|--|
|   | <b>BASIC HMO PLAN</b>  |
|   | <b>IN-NETWORK ONLY</b><br>(out-of-network care is not covered except as noted) |
| <b>22. DURABLE MEDICAL EQUIPMENT<sup>21</sup></b> | <b>50% up to maximum \$800/year paid by plan.</b>                              |

|   |  |
|---|--|
|   | <b>STANDARD HMO PLAN</b>   |
|   | <b>IN-NETWORK ONLY</b><br>(out-of-network care is not covered except as noted) |
| <b>22. DURABLE MEDICAL EQUIPMENT<sup>21</sup></b> | <b>50% up to maximum \$800/year paid by plan.</b>                              |

21. Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. *Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is **not** covered. [Emphases added.]*

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for durable medical equipment are more restrictive than allowed by law. The Company's 2002 Choice HMO Basic and Standard Health Plan certificate of coverage forms fail to include reusable equipment for the treatment of diabetes as a covered benefit. The plan exclusions also state durable medical equipment and prescribed and non-prescribed outpatient supplies are not covered unless specifically stated as a covered benefit. Additionally, the Company limits benefits for the purchase, repair or replacement of a single purchase item to once every three years. Colorado insurance law requires coverage for necessary replacement of defective equipment without a specific time restriction except if the replacement is needed due to misuse or abuse by the insured.

2002 Choice HMO Basic and Standard Health Benefit Plan Certificate of Coverage, states:

6. Durable Medical Equipment

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.

- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, and connectors.)
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and person comfort items are excluded from coverage.)

*We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. [Emphasis added.]*

**20. Prosthetic Devices**

Prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. *Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. [Emphasis added.]*

| <u>Forms</u>  | <u>Date</u> |
|---------------|-------------|
| BASCHCCO.01   | 1/1/2002    |
| STDCHCCO.01   | 1/1/2002    |
| BASCONVCHC.01 | 1/1/2002    |
| STDCONVCHC.01 | 1/1/2002    |

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**Recommendation No. 6:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct benefits for durable medical equipment as required by Colorado insurance law.

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**Issue E6: Failure of the Company's forms to include the provision of complaint forms to enrollees in its complaint procedures.**

Section 10-16-409, C.R.S., Complaint system, states:

- (1) (a) Every health maintenance organization *shall establish and maintain a complaint system which has been approved by the commissioner* [emphasis added], after consultation with the executive director, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

Regulation 4-7-2, amended effective July 1, 2000, Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated pursuant to 10-16-109, C.R.S., states:

Section 5 Requirements for Benefit Contracts and Evidences of Coverage

K. Complaint System

*In compliance with 10-16-409, C.R.S., the contract and/or evidence of coverage shall contain a description of the HMO's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract. . .* [Emphasis added.]

Section 8 Other Requirements

D. Complaint System

2. *An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address and telephone number to which complaints must be directed and shall specify any required time limits imposed by the HMO.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that the complaint procedures included in its Evidence of Coverage do not include a provision for providing a complaint form to be utilized when an enrollee wishes to submit a complaint in writing.

The Evidence of Coverage states only that to resolve a complaint, the member should contact the Company's customer service department, and that (s)he will be given the appropriate address if (s)he wishes to submit the complaint in writing.

The Certificate of Coverage, states:

**Section 6: Questions, Complaints, Appeals**

To resolve a question, complaint, or appeal, just follow these steps:

Contact Our Customer Service Department

... If you would rather send your complaint to us in writing at this point, the  
Customer Service representative can provide you with the appropriate address.

| <u>Forms</u>  | <u>Date</u> |
|---------------|-------------|
| CHOICECO.01   | 10/1/2001   |
| SELECTCO.01   | 10/1/2001   |
| BASCHCCO.01   | 1/1/2002    |
| STDCHCCO.01   | 1/1/2002    |
| BASCONVCHC.01 | 1/1/2002    |
| STDCONVCHC.01 | 1/1/2002    |

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**Recommendation No. 7:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-409, C.R.S. and Amended Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include a provision in its complaint procedures to indicate that complaint forms will be provided to individuals who wish to file a written complaint as required by Colorado insurance law.

**Issue E7: Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years as required by law.**

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

- (7) An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to provisions of this section *shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years from the date of application* [emphasis added]. Medical information which is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or using such information on current health status to underwrite or set premiums for the group.

It appears that the Company's forms are not in compliance with Colorado insurance law in that individual enrollees of small employer groups are required to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period limitation.

The Company's "Employee Enrollment Form", under the "Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage" section contained on the back of the application states the following:

"I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy."

Form

Date:

380-1474 Employee Enrollment Form

9/02

**Recommendation No. 8:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to limit the look-back period to five (5) years as required by Colorado insurance law.

**Issue E8: Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. (This was prior issue E10 in the findings of the 1999 final examination report.)**

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

- (2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.
  - (a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation or a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).
    - (b) (I) An employee shall be eligible to make the election for such employee and the employee's dependents provided for in paragraph (a) of this subsection (2) if:
      - (A) The employee's eligibility to receive insurance coverage has ended for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;
      - (B) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and
      - (C) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.
    - (III) The employer shall not be required to offer continuation of coverage of any person if such person *is covered* [emphasis added] by medicare, Title XVIII of the federal "Social Security Act," or medicaid, Title XIX of the federal "Social Security Act."

- (c) (I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, the employee or dependent has the right to continue the coverage for a period of eighteen months after loss of coverage or until the employee or dependent becomes eligible for *other group coverage* [emphasis added], whichever occurs first. . . .

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that eligibility for continuation coverage is more restrictive than allowed by law. Continuation coverage cannot be denied because an individual is *eligible* for Medicare or Medicaid. Coverage may only be denied if the individual is *covered* under Medicare or Medicaid (*This was prior issue E10 from the 1999 Market Conduct Examination*). In addition, Continuation Coverage cannot be terminated solely because the individual has moved outside the service area. Members are eligible if they either live or work in the service area.

Certificate of Coverage, states:

**Qualifying Events for Continuation Coverage under State Law**

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below: ...

- The Covered Person is not *eligible* for Medicare or Medicaid.
- The Covered Person is not enrolled in Medicare.

**Terminating Events for Continuation Coverage under State Law**

Continuation coverage under the Policy will end on the earliest of the following dates: ...

- The date you move outside the Service Area.

| <u>Forms</u> | <u>Date</u> |
|--------------|-------------|
| CHOICECO.01  | 10/1/2001   |
| SELECTCO.01  | 10/1/2001   |
| BASCHCCO.01  | 1/1/2002    |
| STDCHCCO.01  | 1/1/2002    |

**Recommendation No. 9:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to allow for qualified individuals to enroll in continuation coverage as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to offer state continuation to, and/or to continue state continuation coverage of, some eligible Members. The violation resulted in Recommendation #26, that the Company revise its forms to either correctly specify that initial and continuing coverage is available for Medicare eligibles or to omit the exclusion of Medicare eligibles. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

**Issue E9: Failure of the Company's forms to contain a correct definition of a disabled dependent.**

Section 10-16-102, C.R.S., Definitions, states:

14. "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is *medically certified as disabled and dependent upon the parent*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that coverage for a disabled dependent is more restrictive than permitted by law. Colorado law does not require, as a condition for coverage, a disabled dependent to be unable to be self-supporting or incapacitated. The only condition for coverage under the law for a medically certified disabled dependent is dependency upon the parent.

The Certificate of Coverage, states:

**Coverage for a Handicapped Child**

Coverage for an unmarried Enrolled Dependent child who is not able to be *self-supporting* because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if *both* of the following are true regarding the Enrolled Dependent child:

- *Is not able to be self-supporting because of mental retardation or physical handicap.*
- Depends *mainly* on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is *incapacitated and dependent* unless coverage is otherwise terminated in accordance with the terms of the Policy.

We may continue to ask you for proof that the child continues to meet these conditions of *incapacity and dependency*. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's *incapacity and dependency* within 31 days of our request as described above, coverage for that child will end. [Emphases added.]

**Market Conduct Examination  
Underwriting - Contract Forms**

**United HealthCare of Colorado, Inc.**

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| <u>Forms</u>  | <u>Date</u> |
|---------------|-------------|
| CHOICECO.01   | 10/1/2001   |
| SELECTCO.01   | 10/1/2001   |
| BASCHCCO.01   | 1/1/2002    |
| STDCHCCO.01   | 1/1/2002    |
| BASCONVCHC.01 | 1/1/2002    |
| STDCONVCHC.01 | 1/1/2002    |

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**Recommendation No. 10:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to contain a correct definition of disabled dependent as required by Colorado insurance law.

**Issue E10: Failure of the Company's forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law.**

Section 10-16-201.5(8), C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

- (a) With respect to benefits provided under a small group health benefit plan or individual health benefit plan renewed on or after January 1, 1999, a carrier may make reasonable modifications if:
  - (I) *The modification is effective only upon renewal of such health benefit plan;*
  - (II) *The health benefit plan is uniformly modified for all groups and individuals covered by such health benefit plan;*
  - (III) *To the extent that a health benefit plan already provides the benefits and coverages established in section 10-16-105(7.2) and rules and regulations promulgated thereunder, the proposed modifications to benefits and coverages do not fall below such requirements;*
  - (IV) *The proposed modification is provided to policyholders and the commissioner at least ninety days prior to the effective date of the modification; and*
  - (V) *The carrier provides to each affected policyholder the opportunity to purchase any other health benefit plan offered by the carrier in such market.* [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Certificates of Coverage contain references to changing the provisions of the certificate without reference to the required ninety (90) day notification, or the offer of the opportunity to purchase any other health benefit plans offered by the carrier. Additionally, it appears that modifications made by amendment or rider may not be effective upon the renewal date of the group as stipulated by Colorado insurance law.

Certificate of Coverage, states:

**Changes to the Document**

*We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages.* [Emphasis added.]

No one can make any changes to the Policy unless those changes are in writing.

### Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are *effective 31 days after we send written notice to the Enrolling Group.*
- *Riders are effective on the date we specify.*
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.  
[Emphases added.]

| <u>Forms</u> | <u>Date</u> |
|--------------|-------------|
| CHOICECO.01  | 10/1/2001   |
| SELECTCO.01  | 10/1/2001   |
| BASCHCCO.01  | 1/1/2002    |
| STDCHCCO.01  | 1/1/2002    |

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### Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide members with notification of plan changes according to the time frames required by Colorado insurance law.

**Issue E11: Failure of the Company's forms to provide accurate information concerning premium rate setting.**

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, states:

Section 5. Premium Rate Setting

A. Calculating Premium Rates Adjusted for Case Characteristics

- (1) Index Rate – Each carrier offering a health benefit plan to groups in Colorado shall develop *a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal.* It should be calculated using the experience *for all small group plans.* The premium rate charged during a rating period, *applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.*
- (2) Plan Design Adjustment – The Index Rate may be adjusted to reflect differences attributable to different plan designs. If the small employer carrier elects to make this adjustment, the small employer carrier should calculate a rate adjustment factor for each small group plan design. *Differences in the rates for different benefit plans, for persons with the same case characteristics, shall be attributable to plan design only and shall not reflect actual or expected differences in costs or utilization attributable to the health status of those enrolling under different plans...*[Emphases added.]

C. Rating Period

The rating period for all small group health plans *shall be twelve (12) months* [emphasis added] unless:

- (1) A small employer carrier specifies in its rate filing a different rating period, which shall be the *same for all its health benefit plans issued or renewed in the same calendar month* [emphasis added], pursuant to Section 10-16-105(8)(c)(II), C.R.S.; and
- (2) The small employer carrier clearly discloses in all its small employer solicitation and sales materials exactly what the different rating period is, pursuant to Section 10-16-105(5)(b), C.R.S.

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policy for the Choice and Select Health Benefit Plans contains references to changing the schedule for rates that are outside the provisions allowed for premium adjustments as stipulated by

Colorado insurance law. Additionally, the language in the Group Policy indicates that health status is a factor used to set premiums for the group, which is prohibited by law.

Group Policy, Exhibit 1, states:

**4. Premiums**

We reserve the right to change the schedule of rates for Premiums, after a 31-day prior written notice [<sup>1</sup> on the first anniversary of the effective date of this Policy specified in the application or on any month due date thereafter, or *on any date the provisions of this Policy are amended. We also reserve the right to change the schedule of rates for Premiums, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates.*][<sup>1</sup>at any time.] [Emphasis added.]

Forms

Date

PolicyH.01.CO

10/1/2001

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**Recommendation No. 12:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide accurate information regarding changes in premium rates to ensure compliance with Colorado insurance law.

**Issue E12: Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.**

Section 10-16-104 (1.7) C.R.S., Therapies for congenital defects and birth abnormalities, states:

- (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide *medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.* [Emphasis added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its forms define a Congenital Anomaly as a physical developmental defect that is present at birth *and is identified within the first twelve months of birth.* [Emphasis added. This definition creates the potential to exclude coverage for these conditions during the first five years of life, in that a congenital defect or birth abnormality may have been present at birth, but may not have been identified within the first twelve months of life.

Certificate of Coverage, states:

**Congenital Anomaly** – a physical developmental defect that is present at birth, *and is identified within the first twelve months of birth.* [Emphasis added.]

| <u>Forms</u>  | <u>Dated</u> |
|---------------|--------------|
| CHOICECO.01   | 10/1/2001    |
| SELECTCO.01   | 10/1/2001    |
| BASCHCCO.01   | 1/1/2002     |
| STDCHCCO.01   | 1/1/2002     |
| BASCONVCHC.01 | 1/1/2002     |
| STDCONVCHC.01 | 1/1/2002     |

**Recommendation No. 13:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to eliminate the requirement that congenital anomalies must be identified within the first twelve months of life, to ensure compliance with Colorado insurance law.

**Issue E13: Failure of the Company's forms to provide correct information regarding changes to premium rates.**

Section 10-16-105(8), C.R.S., Small group sickness and accident insurance- guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

- (a)(I) The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage, ...

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, states:

Section 5. Premium Rate Setting

- B. Allowable Rate Adjustment Factor for Small Group Plans Issued or Renewed on or After January 1, 1998

The rate adjustment factor for small group plans issued or renewed on or after January 1, 1998, shall be 1.0. This means the case characteristics-adjusted index rate calculation pursuant to subsection A of Section 5 of this regulation *may not be further adjusted using any other factors* ...[emphasis added]

- D. Administrative and Other Fees

- (1) Carriers and producers *shall not charge any additional fees whatsoever in addition to premium. Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Such charges must be built into the index rate and are not an allowable rate adjustment factor.* ...[Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policies indicate that rates may be adjusted at anytime whenever any change in law that affects the Company's expenses. Carriers may not charge any additional fees in addition to premium except for amounts necessary to recoup assessments for CoverColorado or other recoverable governmental charges. In addition, any change in the Company's small group rates must be filed with the Division of Insurance before the new rates can be used, regardless of the reason(s) that necessitated the change.

Group Policy, states:

3.3 Adjustments to the Policy Charge

. . . If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges shall be automatically added to the Premium. In addition, *any change in law or regulation that significantly affects our cost of operation shall result in an increase in Premium, in an amount we determine.* [Emphasis added.]

Forms

Date

POLICYH.01.CO

10/1/2001

PolicyStdBas.01.CO

1/1/2002

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**Recommendation No. 14:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S and amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide correct information regarding changes to rates to ensure compliance with Colorado insurance law.

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|--|
| <p><b><u>RATE</u></b><br/><b><u>FINDINGS</u></b></p> |
|--|

**Issue F1: Failure to include required information concerning the choice of either age-banded or composite rates.**

Regulation 4-6-7(6), amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, Use of Composite Rates, promulgated under the authority of Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, C.R.S., states:

- A. Small employer carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:
  - (1) Four-tier family, age-banded rated calculated pursuant to Section 5 of this regulation; OR
  - (2) A choice between four-tier, age-banded rates, calculated pursuant to Section 5 of this regulation, and composite rates. It shall be construed that the small employer carrier had offered the small employer a choice between the two methods if, at initial application and *at each renewal*:
    - (a) Both methods are offered to the small employer, *with the difference clearly explained in writing*; OR
    - (b) *The small employer is given a written option to indicate that: 1) both rating methods need be presented; or 2) only age banded rates need be presented; or 3) only the composite rate need be presented. This indication may be a check-off on the application or renewal form or similar form that complies with this section. [Emphases added.]*
- B. Small employer carriers may offer small employers composite rates as an alternative to four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation *if all of the following conditions are met* [emphasis added]:
  - (1) The small employer carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the small employer carrier makes this offer to all small employers having ten (10) or more eligible employees, then the small employer carrier **may** also offer composite rates to small employers having fewer than ten (10) eligible employees. The small employer carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.
  - (2) *The small employer carrier must clearly state on its application and renewal forms for all its small group products the differences between age-banded and composite rates and that either:*

- (a) *The minimum number of eligible employees for calculating composite rates is ten (10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways; [Emphases added.] OR*
- (b) If the number of eligible employees is less than ten (10), the small employer carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates and have the right to see them calculated either or both ways.

Small Group Renewals Sample

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,452      | 50          | 50                   | 100%                 |

It appears that the Company is not in compliance with Colorado insurance law in that its small employer renewal forms do not include the required information stating that employer groups with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates; that employer groups have the right to see what the premium would be quoted either way; and to provide an explanation of the differences between the two rating methods.

The examiners requested a sample of fifty (50) files systematically selected from a total population of 2,452 small group renewal files for groups that were renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) renewal files reviewed, none of the files contained the required small group rating disclosure.

The Company's "Basic and Standard Rate Disclosure" form states "For groups of 10-50 eligible employees, composite rates are also available." However, this disclosure does not meet the small group rating disclosure requirements. The Company's renewal rate quotes do not contain all of the required rate disclosure information. Since the Company has chosen to offer composite rates as an alternative to four-tier family, age-banded rates, it must provide the required disclosure information on its renewal forms.

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**Recommendation No. 15:**

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to provide the required information concerning the group's right to see renewal rates quoted using either age-banded or composite rates, and to explain differences between the two methods as required by Colorado insurance law.

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**UNDERWRITING**  
**APPLICATIONS/RENEWALS**  
**FINDINGS**

**Issue G1: Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents in the waiting period at the time of the initial issue or renewal of the group.**

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., states:

Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado

- V. All basic and standard health benefit plans shall also comply with the following requirements:
  - F. Enrollment – *To enroll an employee and dependents, the carrier shall require that:*
    - 1. Employers:
      - a. Submit a written request for coverage;
      - b. Provide information necessary to determine eligibility; and
      - c. Agree to pay the required premium.
    - 2. *Eligible employees, on a form made available by the employer:*
      - a. *Submit a written request for coverage for himself/herself and any dependents; and*
      - b. Provide information necessary to determine eligibility, if it is required. [Emphases added.]

Regulation 4-6-8(5)(B), amended November 1, 1997, Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, Dependent, promulgated under authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

- (4) *A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage (e.g., covered under spouse's plan, can't afford coverage, etc.) be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for all active employees. [Emphases added.]*

**New Small Group Application Sample**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 1,402      | 50          | 22                   | 44%                  |

**Small Group Renewals Sample**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,452      | 50          | 12                   | 24%                  |

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that, in some instances, it did not obtain either a completed application or a waiver of coverage for all eligible employees and their dependents of small employers who purchased or renewed health benefit plans issued by United HealthCare of Colorado, Inc.

The examiners reviewed a systematically selected sample of fifty (50) new small group application files from a total population of 1,402 new groups sold during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, nineteen (19) files did not contain a total of forty-nine (49) required waivers of coverage for eligible employees and/or their dependents.

Additionally, three (3) files did not contain either a completed application or a waiver of coverage from employees who were in the waiting period at the time the group coverage was initially effective, and who subsequently became eligible for coverage.

The examiners also reviewed a systematically selected sample of fifty (50) small employer group renewal files from a total population of 2,452 small employer groups renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, the Company was unable to provide nine (9) applications or waivers of coverage in eight (8) files pertaining to nine (9) individuals. Additionally, four (4) files did not contain a total of seven (7) required applications or waivers of coverage forms for eligible employees and/or their dependents that were eligible for coverage subsequent to the issuance of the original group contract.

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**Recommendation No. 16:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-6-5 and 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all required applications and/or waivers of coverage are secured and maintained upon the initial issue of the small employer group or subsequent to an employee in the waiting period at initial application becoming an eligible employee as required by Colorado insurance law.

**Issue G2: Failure, in some instances, to include the required Basic and Standard plan disclosure in small group application materials.**

Regulation 4-6-5(III)(E), amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

The following disclosure statement, prominently displayed in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Division of Insurance Regulation 4-2-20), *small employer application forms*, [emphasis added] and small employer renewal notices, and on all written refusals to insure which are related to health coverage for a business group of one.

“COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 – 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.”

| Small Group Application Sample |             |                      |                      |
|--------------------------------|-------------|----------------------|----------------------|
| Population                     | Sample Size | Number of Exceptions | Percentage to Sample |
| 1,402                          | 50          | 14                   | 28%                  |

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications for coverage during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company was not in compliance with Colorado insurance law in that fourteen (14) of the files did not contain the required disclosure statement on the applications.

**Recommendation No. 17:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all new small group application materials contain the required disclosure as required by Colorado insurance law.

**Issue G3: Failure to obtain the required employer provided listing of eligible dependents.**

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214 (1)(d), and 10-16-708, C.R.S., states:

Section 5. Issuance of Coverage

B. Determining Who is an Eligible Employee, Dependent

- 3) A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide *a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* [Emphases added.] The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

Small Group Application Sample

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 1,402      | 50          | 50                   | 100%                 |

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications received during the exam period of January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that none of the sample files contained a list of eligible dependents.

**Recommendation No. 18:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer groups complete an employer provided listing of eligible dependents as required by Colorado insurance law.

**Issue G4: Failure, in some instances, to include the small group disclosure requirements in new application materials.** *(This was prior issue G3 in the findings of the 1999 final examination report.)*

Regulation 4-6-8(9), amended effective November 1, 1997, Concerning Small Employer Health Plans, Disclosure requirements, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-214(1)(d), and 10-16-708, C.R.S., states:

(A) Pursuant to Sections 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, on all printed marketing and solicitation materials for their small group health products and in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:

- (1) Identifies the class of business;
- (2) Specifies case characteristics and rating factors used in setting new and renewal rates and the extent to which they impact premiums;
- (3) Explains the employer's right to renew;

| Small Group Application Sample |             |                      |                      |
|--------------------------------|-------------|----------------------|----------------------|
| Population                     | Sample Size | Number of Exceptions | Percentage to Sample |
| 1,402                          | 50          | 14                   | 28%                  |

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications for coverage received during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that fourteen (14) of the files do not appear to contain the required Small Employer Health Plan disclosure.

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**Recommendation No. 19:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer group application materials contain the required small group disclosure as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to comply with disclosure requirements concerning setting of new and renewal rates and premium impact. The violation resulted in Recommendation #60, that the Company revise its solicitation materials to include the required disclosure statement. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

**Issue G5: Failure, in some instances, to notify the Commissioner of Insurance and policyholders prior to the modification and/or discontinuation of small employer group health benefit plans.**

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

- (6) A group health benefit plan carrier *may discontinue offering a particular type of group health coverage if:*
  - (a) The group health carrier provides notice of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage to each policyholder provided this type of coverage and each certificate holder, participant, and beneficiary covered by such a policy; [emphases added]
- (8) (a) With respect to benefits provided under a small group health benefit plan or individual health benefit plan renewed on or after January 1, 1999, a carrier may make reasonable modifications if:
  - (I) The modification is effective only upon renewal of such health benefit plan;
  - (II) The health benefit plan is uniformly modified for all groups and individuals covered by such health benefit plan;
  - (III) To the extent a health benefit plan already provides the benefits and coverages established in section 10-16-105 (7.2) and rules and regulations promulgated thereunder, the proposed modifications to benefits and coverages do not fall below such requirements;
  - (IV) *The proposed modification is provided to policyholders and the commissioner at least ninety days prior to the effective date of the modification* [emphasis added]; and
  - (V) The carrier provides to each effected policyholder the opportunity to purchase any other health benefit plan offered by the carrier in such market.

| Small Group Renewals Sample |             |                      |                      |
|-----------------------------|-------------|----------------------|----------------------|
| Population                  | Sample Size | Number of Exceptions | Percentage to Sample |
| 2,452                       | 50          | 39                   | 78%                  |

It appears that the Company is not in compliance with Colorado insurance law in that it modified and/or discontinued some of its HMO small employer group health benefit plans and replaced them with new plan designs without the required notice to the Commissioner of Insurance.

The examiners reviewed a systematically selected sample of fifty (50) small employer group renewal files from a total population of 2,452 small employer groups renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, thirty-nine (39) groups with a renewal

date of March 1, 2002, were notified that effective on their renewal date, their current health benefit plan was no longer being offered and was being replaced by new plan designs. However, it does not appear that these modifications and/or discontinuations were communicated to the Commissioner of Insurance.

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**Recommendation No. 20:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the Commissioner of Insurance and all policyholders are notified prior to the modification and/or discontinuation of any health benefit plan as required by Colorado insurance law.

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| <p style="text-align: center;"><b><u>UNDERWRITING</u></b><br/><b><u>CANCELLATIONS/NON-RENEWALS/DECLINATIONS</u></b><br/><b><u>FINDINGS</u></b></p> |
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**Issue H1: Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied.** *(This was prior issue H2 in the findings of the 1999 final examination report.)*

Section 10-16-108.5, C.R.S., Fair marketing standards, states:

- (7) *Any denial by a carrier of an application for coverage from an individual or a small employer, shall be in writing and shall state any reason for the denial.*  
[Emphasis added.]

DECLINED SMALL GROUP FILE SAMPLE – Written Notification

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 34         | 34          | 4                    | 12%                  |

The examiners reviewed the files for the entire population of thirty-four (34) small groups whose applications for coverage were declined during the period January 1, 2002 through December 31, 2002. It appears the Company is not in compliance with Colorado insurance law in that four (4) files did not contain evidence that a written denial had been provided to the applicant

**Recommendation No. 21:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 10-16-108.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to include the required written notification to all small employers who are denied coverage as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998 the Company was cited for failure to notify or incomplete notification of denial of coverage. The violation resulted in Recommendation #63, that the Company revise its procedures and forms to ensure that written denials are issued with all the information required by Regulation. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

**Issue H2: Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law.**

Section 10-16-102, C.R.S., Definitions, states:

- (6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has taxable income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated taxable income in one of the two previous years or from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of any consecutive three-year period. For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the *business group of one* that are sufficient to pay for annual health insurance premiums for the *business group of one*. [Emphases added.]
- (15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.
- (b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer *who could also be considered a dependent of the small employer* [emphasis added] shall receive taxable income from such small employer in an amount equivalent to minimum wage for working twenty-four hours per week on a permanent basis in order for the employer group to be considered a business group of two or more.
- (40) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, "small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

- (7.3)(a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; except that this requirement shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).
- (c) (I) Effective January 1, 1995, a small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with this article. Effective July 1, 1997, a small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially-based underwriting criteria. The requirements of this subparagraph (I) shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214 (1)(d), and 10-16-708, C.R.S., states:

**Section 5. Issuance of Coverage**

**B. Determining Who is an Eligible Employee, Dependent**

- 3) A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list. *The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.* [Emphasis added.]

**SMALL GROUP DECLINED FILE SAMPLE**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 34         | 34          | 3                    | 9%                   |

The examiner reviewed the entire population of thirty-four (34) small groups whose applications for coverage were declined during calendar year 2002. It appears that the Company is not in compliance with law in that three (3) of the groups, appeared to meet the requirements to be eligible for small group coverage, but were incorrectly declined. It appears that in some cases, the Company requires groups of 2-50 employees to provide income tax documentation with their applications in order to prove sufficient income to pay premiums. Although Colorado insurance law does permit insurance companies to request copies of the W2 Summary Wage and Tax Forms in order to verify employee eligibility, other income tax information to verify sufficient income cannot be requested except for business groups of one.

**Recommendation No. 22:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-105, C.R.S, and Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has changed its procedures to ensure that groups of 2-50 eligible employees are guaranteed issuance of coverage as required by Colorado insurance law.

**Issue H3: Failure to examine all applicable tax returns when determining eligibility of business groups of one.**

Section 10-16-102, C.R.S., Definitions, states:

- (6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has gross income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes *which generated gross income from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive three-year period.* [Emphasis added.] For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.

SMALL GROUP DECLINED FILE SAMPLE

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 34         | 34          | 11                   | 32%                  |

The examiners reviewed the entire population of thirty-four (34) small groups whose applications for coverage were declined during calendar year 2002. Eleven (11) of these declinations appeared to involve business groups of one. It appears that the Company is not in compliance with Colorado insurance law in that in all eleven (11) cases involving business groups of one, only one year of tax records was reviewed, rather than the records from the most recent consecutive three (3) year period. None of the files examined contained any evidence that the Company obtained tax information for the entire three (3) years or that it requested tax information for another year if the information initially provided did not show sufficient income.

**Recommendation No. 23:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it modified its procedures pertaining to reviewing tax documentation to ensure compliance with Colorado insurance law.

**Issue H4: Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups.**

Section 10-16-108(4) C.R.S., Conversion and continuation privileges, Special provisions for small group health benefit plans, states:

- (a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan* [emphasis added], except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policy holder exercising the right to cancel.
- (c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:
  - (I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and
  - (II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

SMALL GROUP CANCELLED FILE SAMPLE

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 691        | 50          | 17                   | 34%                  |

The examiners reviewed a sample of fifty (50) files that were systematically selected from a population of 691 files identified as small group cancellations during the exam period of January 1, 2002 through December 31, 2002. It appears that the Company is not in compliance with the requirements of Colorado insurance law in that in seventeen (17) cases, upon the termination of the group policy for reasons other than replacement of coverage, the Company failed to offer to each member of the terminating small group *a choice of the Basic or Standard Health Benefit Plan* as required by law. It appears that in some cases, the Company supplied to the terminating employer, a generic letter directing the members to refer to their contract documents to determine if a conversion policy was available to them. The letter states:

**Notice of Termination of Group Coverage**

This is to notify you that your group coverage with UNITED HEALTHCARE is terminating. The termination date of your group coverage is shown above.

As a result of termination of your group coverage, certain rights may become available to you. We urge you to refer to your contract documents in order to determine what rights, if any, are available to you.

**. . . Group Health Conversion (Refer to your contract documents)**

When a privilege of conversion of group health coverage is present in your contract documents, you must exercise the privilege within 31 days after the date of termination of group coverage. If you wish to exercise any available group health conversion privilege, you should contact the Conversion Customer Service Unit. . . .

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**Recommendation No. 24:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that a choice of the Basic or Standard Health Benefit Plans is offered to each member of the group whose policy is terminating as required by Colorado insurance law. .

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| <p><b><u>CLAIMS</u></b><br/><b><u>FINDINGS</u></b></p> |
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**Issue J1: Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges.**

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-16-106.5, C.R.S., Prompt payment of claims -- legislative declaration, states:

- (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
- (4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. [Emphasis added.]* The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.

DENIED CLAIMS SAMPLE

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 64,345     | 100         | 14                   | 14%                  |

From a population of 64,345 claims received from January 1, 2002, through December 31, 2002, a systematically selected a sample of 100 claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time the claims were denied, it appears that the Company:

- in ten (10) cases, was in possession of the information it needed to properly adjudicate the claims; and
  - in four (4) cases it failed to request any required additional information prior to denying the claim.
- 

**Recommendation No. 25:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that its processing staff is properly trained to request any additional information necessary to resolve a claim, and to make appropriate decisions when all required information is present, to avoid denying eligible claims as required by Colorado insurance law.

**Issue J2: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.**

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

- (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
- (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphasis added.]
- (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

**CLEAN ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 3,343*     | 50          | 38                   | 76%                  |

(\*1% of all electronic claims)

**CLEAN NON-ELECTRONIC CLAIMS PROCESSED OVER 45 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5,673*     | 100         | 78                   | 78%                  |

(\*5% of all non-electronic claims)

**CLAIMS PROCESSED OVER 90 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Population |
|------------|-------------|----------------------|--------------------------|
| 4,816*     | N/A         | 4,816                | 100%                     |

(\*1% of all processed claims)

The examiners reviewed a population of 329,444 claims, which represented all HMO claims that had been submitted to the Company electronically, and 110,321 claims representing all HMO claims that had been submitted in paper form. Using ACL™ software, the examiners identified a population of 3,343 electronic claims not paid, denied, or settled within thirty (30) days, and a population of 5,673 non-electronic claims not paid, denied, or settled within forty-five (45) days. The examiners selected a systematic sample of fifty (50) claims from the population of electronic claims over thirty (30) days, and a sample of 100 non-electronic claims over forty-five (45) days.

In addition, the examiners identified 4,816 claims out of a total population of 439,765 claims that were not paid, denied, or settled within ninety (90) days. None of these claims included any indication that they had been delayed due to fraud.

It appears that the Company is not in compliance with Colorado law in that:

- Thirty-eight (38) of the fifty (50) electronic claims reviewed appeared to represent clean claims, but were not paid or settled within thirty (30) days;
  - Seventy-nine (79) of the 100 non-electronic claims reviewed appeared to represent clean claims but were not paid or settled with forty-five (45) days;
  - 4,816 of the total population of 439,765 claims did not appear to involve fraud, but were not paid, denied, or settled within ninety (90) days.
- 

**Recommendation No. 26:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all clean electronic claims are paid, denied, or settled within thirty (30) days; all clean non-electronic claims are paid, denied, or settled with forty-five (45) days; and except where fraud is involved, all claims are paid, denied, or settled within ninety (90) days as required by Colorado insurance law.

**Issue J3: Failure, in some instances, to pay interest and/or penalties on claims that were not paid or settled within the time periods required by Colorado insurance law.**

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

- (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
- (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.
- (5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section. [Emphasis added.]*
- (a) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to three percent of the total amount ultimately allowed on the claim. Such penalty shall be due on the ninety-first day after receipt of the claim by the carrier.

**PAID ELECTRONIC CLAIMS OVER 30 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 3,343*     | 50          | 25                   | 50%                  |

(\*1% of all electronic claims)

**PAID NON-ELECTRONIC CLAIMS OVER 45 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5,673*     | 100         | 33                   | 33%                  |

(\*5% of all non-electronic claims)

**PAID CLAIMS OVER 90 DAYS**

| Population | Sample Size | Number of Exceptions | Percentage to Population |
|------------|-------------|----------------------|--------------------------|
| 4,816*     | N/A         | 4,816                | 100%                     |

(\*1% of all processed claims)

Using ACL™ software, the examiners reviewed the entire population of 439,765 HMO paid claims provided by the Company. The examiners identified 4,816 claims out of the population of 439,765 paid claims that appear not to have been paid or settled within the ninety (90) days allowed by law. The claims data provided to the examiners by the Company did not indicate that the required penalty payment for unsettled claims over ninety (90) days had been paid.

The examiners also identified a population of 3,343 claims that were not paid or settled within thirty (30) days and a population of 5,673 claims that were not paid or settled within forty-five (45) days. A sample of fifty (50) claims over thirty (30) days and 100 claims over forty-five (45) days were systematically selected from each of these populations, respectively. From these samples, it was determined that thirty-eight (38) claims out of the fifty (50) electronically submitted claims not paid or settled within thirty (30) days and thirty-four (34) claim out of the 100 non-electronically submitted claims not paid or settled within forty-five (45) days were clean claims and therefore should have been paid or settled within the required timeframes.

It appears that the Company is not in compliance with Colorado insurance law in that twenty-five (25) of the fifty (50) claims paid over thirty (30) days and thirty-three (33) of the 100 non-electronic claims over forty-five (45) days did not include payment of the required ten (10) percent annual interest on the amount ultimately allowed on the claim, accruing from the date the payment was made.

It also appears that the Company is not in compliance with Colorado insurance law in that it failed to pay a three (3) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91<sup>st</sup>) day for all claims not paid or settled within ninety (90) days.

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**Recommendation No. 27:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that interest is paid on clean, electronic claims not paid within thirty (30) days, all clean, non-electronic claims not paid within forty-five (45), and a three percent (3%) penalty is paid on the ninety-first (91<sup>st</sup>) day for all claims not paid within ninety (90) days. The Company should work with the Division of Insurance to ensure that all past due interest and penalties are paid.

**Issue J4: Failure, in some instances, to process claims accurately.**

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices,

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; ...

HMO PAID CLAIMS SAMPLE

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 375,420    | 100         | 8                    | 8%                   |

Systematically selected samples were chosen for review of processing from the population of HMO claims received from January 1, 2002 through December 31, 2002. The populations, sample sizes, number of exceptions and percentage to the sample are reflected above. It appears that the Company is not in compliance with Colorado insurance law in that eight (8) claims do not appear to have been processed correctly based on a review of the information provided. The errors included incorrect application of copays, coinsurance, and deductibles.

**Recommendation No. 28:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine the proper allocation of benefits to ensure compliance with Colorado insurance law.

**UTILIZATION REVIEW**  
**FINDINGS**

**Issue K1: Failure, in some instances, to make Utilization Review determinations and provide required notifications within the timeframes allowed under Colorado insurance law.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

**Section VI. Procedures for Review Decisions**

- A. A health carrier shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.
- B. For prospective review determinations, a health carrier *shall make the determination within two (2) working days of obtaining all necessary information* [emphasis added] regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.
  - 1) In the case of a determination to certify an admission, procedure or service, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and/or the provider within two (2) working days of making the initial certification.* [Emphases added.]
  - 2) In the case of an adverse determination, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination;* [Emphasis added.] and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.
- C. 1) For concurrent review determinations, a health carrier *shall make the determination within one (1) working day of obtaining all necessary information.* [Emphasis added.]

- 2) In the case of a determination to certify an extended stay or additional services, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification.* The written or electronic notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. [Emphases added.]
  - 3) In the case of an adverse determination, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination;* [Emphasis added.] and shall provide written or electronic confirmation to the covered person and the provider within one (1) working day after the telephone notification. The service shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination.
- D. For retrospective review determinations, a health carrier *shall make the determination within thirty (30) working days of receiving all necessary information.* [Emphasis added.] In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two (2) working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within thirty (30) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.
- 1) In the case of a certification, the carrier *shall notify in writing the covered person and the provider rendering the service within five (5) working days of making the determination to provide coverage.* [Emphasis added.]
  - 2) In the case of an adverse determination, the carrier *shall notify in writing the provider rendering the service and the covered person within five (5) working days of making the adverse determination.* [Emphasis added.]
- E. A written notification of an adverse determination shall include the principal reason for the determination, the instructions for initiating an appeal or reconsideration of the determination, *including expedited appeals, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and*

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*who follows the procedures for a request.* [Emphasis added.] A carrier shall specify that such an appeal process shall include a two-level internal review, except as provoked for in section 8.I.A.5. of this regulation.

**APPROVED UR DECISIONS - DETERMINATION**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,633      | 50          | 9                    | 18%                  |

**APPROVED UR DECISIONS – TELEPHONE NOTIFICATION**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,633      | 50          | 22                   | 44%                  |

**APPROVED UR DECISIONS – WRITTEN NOTIFICATION**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,633      | 50          | 17                   | 34%                  |

The examiners reviewed a systematically selected sample of fifty (50) files from a summarized population of 2,633 utilization review approvals made during the examination period. It appears that the Company is not in compliance with law in that:

1. Information in nine (9) of the files indicated that the determination to certify the requested admission, procedure or service had not been made within two (2) working days in the case of prospective reviews, or within one (1) working day in the case of concurrent reviews.
2. Twenty-two (22) files did not include documentation that the provider had been notified by telephone within one (1) working day of making the initial certification.
3. Seventeen (17) files did not include documentation that the covered person and/or the provider had been provided with written or electronic confirmation of the telephonic notification within two (2) working days for the prospective review determinations, within one (1) working day for concurrent review determinations, or within five (5) working days for retrospective reviews.

**UTILIZATION REVEIW DENIALS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 132        | 49          | 3                    | 6%                   |

**UTILIZATION REVIEW DENIALS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 132        | 49          | 16                   | 33%                  |

**UTILIZATION REVIEW DENIALS**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 132        | 49          | 4                    | 8%                   |

The examiners requested a sample of fifty (50) files from a summarized population of 132 utilization review denials made during the examination period. The Company was unable to provide one (1) file, which resulted in a sample of forty-nine (49) files. It appears that the Company is not in compliance with Colorado insurance law in that:

1. Information in three (3) of the files indicates that the determinations for the requested admission, procedure or service had not been made within two (2) working days in the case of prospective reviews, within one (1) working day in the case of concurrent reviews, or within thirty (30) working days in the case of retrospective reviews.
  2. Information in sixteen (16) of the files indicates that the provider had not been notified by telephone within one (1) working day of making the adverse determination.
  3. Information in four (4) of the files indicates that the covered person and/or the provider had not been provided with written or electronic confirmation of the telephonic notification within two (2) working days for the prospective review determinations, within one (1) working day for concurrent review determinations, or within five (5) working days for retrospective reviews.
- 

**Recommendation No. 29:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the timeframes for determination and notification of utilization review decisions meet the requirements of Colorado insurance law.

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| <b>Issue K2: Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals.</b> |
|--|

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

**Section VI. Procedures for Review Decisions**

- A. A health carrier shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.
- B. For prospective review determinations, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.
  - 1. In the case of a determination to certify an admission, procedure or service, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and *shall provide written or electronic confirmation of the telephone notification* [emphasis added] to the covered person and/or the provider within two (2) working days of making the initial certification
- C.
  - 1. For concurrent review determinations, a health carrier shall make the determination within one (1) working day of obtaining all necessary information.
  - 2. In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification. *The written or electronic notification shall include the number of extended days or next review date, the new total number of days or*

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*services approved, and the date of admission or initiation of services.*  
[Emphasis added.]

**APPROVED UR DECISIONS – WRITTEN NOTIFICATION**

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 2,633      | 50          | 13                   | 26%                  |

The examiners reviewed a systematically selected sample of fifty (50) files from a summarized population of 2,633 utilization review approvals made during the examination period of January 1 to December 31, 2002. It appears that the Company is not in compliance with law in that:

1. Notification letters in three (3) of the prospective review files did not clearly indicate that the requested service had been authorized;
2. Notification letters in seven (7) of the concurrent review files did not include documentation regarding the number of extended days or the next review date, the total number of days or services approved, and the date of admission or initiation of services; and
3. Notification letters in three (3) of the files contained a statement the patient would not be notified of the total days authorized and the authorization number until after discharge.

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**Recommendation No. 30:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review approval procedures to ensure that the notification sent to members complies with the requirements of Colorado insurance law.

**Issue K3: Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8. Appeals of Adverse Determinations

A. First Level Appeal Review

3. *For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal [emphasis added]...*

LEVEL I APPEALS

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 21         | 21          | 6                    | 29%                  |

It appears that, in some instances, the Company is not in compliance with Colorado insurance law in that its review of First Level Appeals did not meet the requirements for responding in a timely manner.

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado law in that information in two (2) of the cases indicated that the Company did not provide written notice of its decision within the required twenty (20) working day timeframe. In an additional four (4) instances, the appeal files provided to the examiners did not contain sufficient documentation to determine when the written notice was provided.

**Recommendation No. 31:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notification of First Level appeal decisions is completed within the timeframes required by Colorado insurance law.

**Issue K4: Failure, in some instances, to include all required components in First Level appeal determination letters.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8. Appeals of Adverse Determinations

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain:*
  - a. *The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposes of the section, the physician and the consulting clinical peers shall be called "the reviewers");*
  - b. *A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;*
  - c. *The reviewers' decision in clear terms and the medical rationale in sufficient details for the covered person to respond further to the health carrier's position;*
  - d. *A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria; and*
  - e. *A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.*

[Emphases added.]

LEVEL I APPEALS – Written Notification

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 21         | 21          | 19                   | 90%                  |

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado insurance law in that:

1. In seven (7) of the twenty-one (21) cases reviewed, the qualifying credentials of either the reviewing physician or clinical peer reviewer were not provided in the Company's written response. There were six (6) additional cases where the examiners were not provided the appropriate documentation to review this requirement.
  2. Additionally, there were six (6) cases where the examiners were unable to determine if the Company's written response contained a statement of the reviewers understanding of the reason for the appeal, and the required information relating to the process for initiating a Second Level appeal due to a lack on documentation in the files.
- 

**Recommendation No. 32:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that First Level appeal determination letters contain all the information required by Colorado insurance law.

**Issue K5: Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination.**

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

- (3) (b) (II) *The first level appeal shall be a review by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer or peers shall not have been involved in the initial denial [emphasis added].* However, a person that was previously involved with the denial may answer questions...

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8. Appeals of Adverse Determinations

A. First Level Appeal Review

2. *Appeals shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer(s) shall not have been involved in the initial adverse decision.* However, a person that was previously involved with the denial may answer questions. [Emphases added.]

LEVEL I APPEALS – Reviewer Procedure

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 21         | 21          | 20                   | 95%                  |

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that:

1. In seven (7) of the twenty-one (21) cases reviewed, the appeal case was not reviewed by an appropriate clinical peer.
2. In nine (9) of the twenty-one (21) cases reviewed, it appears that the physician who made the original adverse determination was also involved with the review and appeal decision.
3. In four (4) of the twenty-one (21) cases, the examiners were unable to review this information due to a lack of documentation provided by the Company.

**Recommendation No. 33:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S., and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its first level appeal review procedures to ensure compliance with Colorado insurance law.

**Issue K6: Failure, in some instances, to notify members fifteen (15) days in advance of the hearing date for second level appeals.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8 Appeals of Adverse Determinations

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:
  - a) The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carriers expense, by conference call, video conferencing, or other appropriate technology. *The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date. [Emphasis added]...*

Level II Determinations

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5          | 5           | 2                    | 40%                  |

It appears that, in some instances, the Company is not in compliance with Colorado insurance law in that its review of Second Level Appeals did not meet the requirements for timely notification to the member regarding the scheduling of a review panel.

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. In two (2) cases, the member requesting the appeal was not notified in writing at least fifteen (15) working days in advance of the scheduled date of the review hearing.

**Recommendation No. 34:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its second level appeal review procedures to ensure compliance with Colorado insurance law.

**Issue K7: Failure, in some instances, to ensure that second level appeal panels include a majority of health care professionals with appropriate expertise to review the case.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8 Appeals of Adverse Determinations

B. Second Level Appeal Review

- 2) *A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise [emphasis added].* Such reviewing health care professionals shall meet the following criteria: not have been directly involved in the care previously; not be a member of the board of directors of the health plan; not have been involved in the review process for the covered person previously; and not have a direct financial interest in the case or the outcome of the review...

LEVEL II APPEALS

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5          | 5           | 1                    | 20%                  |

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company was not in compliance with Colorado insurance law in that in one (1) of the five (5) cases reviewed, the majority of members comprising the second level appeal panel did not appear to be health care professionals with appropriate expertise to review the issue being appealed.

**Recommendation No. 35:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its second level appeal review procedures to ensure compliance with Colorado insurance law.

**Issue K8: Failure to include all the required elements in written notifications of second level appeal rights.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8 Appeals of Adverse Determinations

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:
  - a. The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date.
  - b) Upon request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged under state or federal law.
  - c) A covered person has the right to:
    1. Attend the second level review;
    2. *Present his or her case to the review panel in person or in writing;*
    3. *Submit supporting material both before and at the review meeting;*
    4. *Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and*

5. *Be assisted or represented by a person of his or her choice.*

d) *The notice shall advise the covered person of the rights specified in this section 8.I.B... [Emphases added.]*

LEVEL II APPEALS

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5          | 5           | 5                    | 100%                 |

It appears that the notification of appeal rights disclosure provided by the Company to covered persons requesting a second level appeal does not meet the requirements of Colorado insurance law in that it fails to disclose all mandated rights of the member initiating the appeal. While the Company's disclosure does notify the member of his or her right to appear before the panel, its fails to disclose the right of the Member to:

1. Present his or her case to the review panel in person or in writing;
2. Submit supporting material both before and at the review meeting;
3. Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and
4. Be assisted or represented by a person of his or her choice.

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**Recommendation No. 36:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all second level appeal notifications disclose all mandated rights of the person initiating the appeal as required by Colorado insurance law.

**Issue K9: Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determinations.**

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8. Appeals of Adverse Determinations

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:
  - g. The review panel, after private deliberation, shall issue a written decision to the covered person within five (5) working days of completing the review meeting. The decision shall include:
    1. *The names, titles, and qualifying credentials of the members of the review panel;*
    2. *A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;*
    3. The rationale for the review panel's decision;
    4. *Reference to evidence or documentation considered by the review panel in making that decision;*
    5. *In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to the covered person, if any; and*
    6. *Effective June 1, 2000, notice of the covered person's right to request an independent external review. The notice shall comply with Section 5 of insurance Regulation 4-2-21.*  
[Emphases added.]

Regulation 4-2-21, effective June 1, 2000, External Review of Benefit Denial of Health Coverage Plans, promulgated pursuant to 10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

Section 5. Notice and Disclosure of Right to External Review

- A. (1) A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in (2) of this Subsection A at the time the carrier sends written notice of carrier's final adverse determination.
- (2) *The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B [emphasis added], including the provisions in the external review procedures that give the covered person or the covered person's designated representative the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance.*

LEVEL II APPEALS – WRITTEN NOTIFICATION

| Population | Sample Size | Number of Exceptions | Percentage to Sample |
|------------|-------------|----------------------|----------------------|
| 5          | 5           | 5                    | 100%                 |

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. It appears that in some instances, the Company was not in compliance with the requirements of Colorado insurance law in that:

- 1) In all five (5) of the cases reviewed, the Company's written notification to the covered person of the review panel's decision did not contain one or more of the following required disclosure elements pertaining to the decision:
  - Names, titles or qualifying credentials of the member of the review panel members;
  - Statement of the panel's understanding of the nature of the appeal; or
  - Reference to evidence or documentation considered by the panel in making a decision.
- 2) In the two (2) of the five (5) cases reviewed that were adverse determinations, the Company's written notification to the covered person did not fully disclose one or more of the following required elements pertaining to the covered person's right to an external review and procedures to initiate such a review:
  - Instructions for requesting a written statement of the clinical rationale used to make the adverse determination; and
  - Notice of the covered persons right to request an independent external review, including the procedures in requesting a standard and expedited external review..

**Recommendation No. 37:**

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-17 and 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that second level appeal notifications include all the required elements pertaining to the appeal decision and the person's right to an external review as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

| ISSUES   | Rec. No. | Page No. |
|--|----------|----------|
| <b>COMPANY OPERATIONS - MANAGEMENT</b>   |          |          |
| Issue A1: Failure to correctly and completely list all applicable forms in the "Colorado Annual Report of Health Coverage Forms".  | 1.       | 21       |
| <b>UNDERWRITING CONTRACT- FORMS</b>  |          |          |
| Issue E1: Failure of the Company's forms to allow for coverage of otherwise eligible dependents who do not reside within the service area.   | 2.       | 24       |
| Issue E2: Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.  | 3.       | 26       |
| Issue E3: Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.   | 4.       | 30       |
| Issue E4: Failure of the Company's Standard Health Benefit Plan forms to exclude copayments for physician ordered lab and x-ray services.  | 5.       | 32       |
| Issue E5: Failure of the Company's forms to provide durable medical equipment benefits in accordance with Colorado insurance law.  | 6.       | 35       |
| Issue E6: Failure of the Company's forms to include the provision of complaint forms to enrollees in its complaint procedures.   | 7.       | 37       |
| Issue E7: Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years as required by law.   | 8.       | 38       |
| Issue E8: Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. <i>(This was prior issue E10 in the findings of the 1999 final examination report.)</i>         | 9.       | 41       |
| Issue E9: Failure of the Company's forms to contain a correct definition of a disabled dependent.  | 10.      | 43       |
| Issue E10: Failure of the Company's forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law.   | 11.      | 45       |
| Issue E11: Failure of the Company's forms to provide accurate information concerning premium rate setting.   | 12.      | 47       |
| Issue E12: Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.  | 13.      | 48       |
| Issue E13: Failure of the Company's forms to provide correct information regarding changes to premium rates.   | 14.      | 50       |
| <b>UNDERWRITING - RATES</b>  |          |          |
| Issue F1: Failure to include required information concerning the choice of either age-banded or composite rates.   | 15.      | 53       |
| <b>UNDERWRITING - APPLICATIONS</b>   |          |          |
| Issue G1: Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents in the waiting period at the time of the initial issue or renewal of the group. | 16.      | 56       |
| Issue G2: Failure, in some instances, to include the required Basic and  | 17.      | 57       |

| ISSUES   | Rec. No. | Page No. |
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| <b>Standard plan disclosure in small group application materials.</b>  |          |          |
| <b>Issue G3: Failure to obtain the required employer provided listing of eligible dependents.</b>  | 18.      | 58       |
| <b>Issue G4: Failure, in some instances, to include the small group disclosure requirements in new application materials. (This was prior issue G3 in the findings of the 1999 final examination report.)</b>                          | 19.      | 59       |
| <b>Issue G5: Failure, in some instances, to notify the Commissioner of Insurance and policyholders prior to the modification and/or discontinuation of small employer group health benefit plans.</b>                                  | 20.      | 61       |
| <b>UNDERWRITING – CANCELLATIONS/NONRENEWALS/DECLINATIONS</b>   |          |          |
| <b>Issue H1: Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied. (This was prior issue H2 in the findings of the 1999 final examination report.)</b> | 21.      | 63       |
| <b>Issue H2: Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law.</b>  | 22.      | 66       |
| <b>Issue H3: Failure to examine all applicable tax returns when determining eligibility of business groups of one.</b>   | 23.      | 67       |
| <b>Issue H4: Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups.</b>  | 24.      | 69       |
| <b>CLAIMS</b>  |          |          |
| <b>Issue J1: Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges.</b>  | 25.      | 72       |
| <b>Issue J2: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.</b>  | 26.      | 74       |
| <b>Issue J3: Failure, in some instances, to pay interest and/or penalties on claims that were not paid or settled within the time periods required by Colorado insurance law.</b>  | 27.      | 76       |
| <b>Issue J4: Failure, in some instances, to process claims accurately.</b>   | 28.      | 77       |
| <b>UTILIZATION REVIEW</b>  |          |          |
| <b>Issue K1: Failure, in some instances, to make Utilization Review determinations and provide required notifications within the timeframes allowed under Colorado insurance law.</b>  | 29.      | 82       |
| <b>Issue K2: Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals.</b>   | 30.      | 84       |
| <b>Issue K3: Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days.</b>  | 31.      | 85       |
| <b>Issue K4: Failure, in some instances, to include all required components in First Level appeal determination letters.</b>   | 32.      | 87       |
| <b>Issue K5: Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination.</b>  | 33.      | 89       |
| <b>Issue K6: Failure, in some instances, to notify members fifteen (15) days in advance of the hearing date for second level appeals.</b>  | 34.      | 91       |
| <b>Issue K7: Failure, in some instances, to ensure that second level appeal</b>  | 35.      | 92       |

| ISSUES   | Rec. No. | Page No. |
|--|----------|----------|
| panels include a majority of health care professionals with appropriate expertise to review the case.  |          |          |
| Issue K8: Failure to include all the required elements in written notifications of second level appeal rights.   | 36.      | 94       |
| Issue K9: Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determinations. | 37.      | 97       |
|  |          |          |

State Market Conduct Examiners

Jeffory Olson, CIE, AIRC, ALHC  
David M. Tucker, AIE, FLMI, ACS  
Maggie Caouette  
Amy Gabert  
Kit Tucker

For

The Colorado Division of Insurance  
1560 Broadway, Suite 850  
Denver, Colorado 80202

participated in this examination and in the preparation of this report.

**BEFORE THE DIVISION OF INSURANCE**

**STATE OF COLORADO**

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**FINAL AGENCY ORDER O-04-141**

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**IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF UNITED  
HEALTHCARE INSURANCE COMPANY,**

**Respondent**

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**THIS MATTER** comes before the Colorado Commissioner of Insurance (the "Commissioner") as a result of a market conduct examination conducted by the Colorado Division of Insurance (the "Division") of United Healthcare Insurance Company (the "Respondent"), pursuant to §§ 10-1-201 to 207, C.R.S. The Commissioner has considered and reviewed the market conduct examination report dated October 9, 2003 (the "Report"), relevant examiner work papers, all written submissions and rebuttals, and the recommendations of staff. The Commissioner finds and orders as follows:

**FINDINGS OF FACT**

1. At all relevant times, the Respondent was licensed by the Division as an indemnity, accident and health insurance company.
2. In accordance with §§ 10-1-201 to 207, C.R.S., on October 9, 2003, the Division completed a market conduct examination of the Respondent. The period of examination was January 1, 2002 to December 31, 2002.
3. In scheduling the market conduct examination and in determining its nature and scope, the Commissioner considered such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, complaint analyses, underwriting and claims practices, pricing, product solicitation, policy form compliance, market share analyses, and other criteria as set forth in the most recent available edition of the examiners' handbook adopted by the National Association of Insurance Commissioners, as required by § 10-1-203(1), C.R.S.
4. In conducting the examination, the examiners observed those guidelines and procedures set forth in the most recent available edition of the examiners' handbook adopted by the National Association of Insurance Commissioners and the Colorado insurance examiners handbook. The Commissioner also employed other guidelines and procedures that he deemed appropriate, pursuant to § 10-1-204(1), C.R.S.

5. The market conduct examiners prepared a Report. The Report is comprised of only the facts appearing upon the books, records, or other documents of the Respondent, its agents or other persons examined, or as ascertained from the testimony of the Respondent's officers or agents or other persons examined concerning Respondent's affairs. The Report contains the conclusions and recommendations that the examiners find reasonably warranted based upon the facts.
6. Respondent delivered to the Division written submissions and rebuttals to the Report.
7. The Commissioner has fully considered and reviewed the Report, all of Respondent's submissions and rebuttals, and all relevant portions of the examiner's work papers.

#### **CONCLUSIONS OF LAW AND ORDER**

8. Unless expressly modified in this Final Agency Order ("Order"), the Commissioner adopts the facts, conclusions and recommendations contained in the final Report. A copy of the final Report is attached to the Order and is incorporated by reference.
9. Issue E1 concerns the following violation: Failure of the forms to provide coverage for dental care resulting from accidents in all instances required by law. The Respondent shall provide evidence that it revised all its affected forms to remove the restrictions on dental coverage as the result of accidents to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
10. Issue E2 concerns the following violation: Failure of the forms to provide a complete and accurate description of the required hospice care benefits. The Respondent shall provide evidence that it revised all affected forms to reflect the correct and accurate description of the required hospice care benefits to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
11. Issue E3 concerns the following violation: Failure of the forms to provide durable medical equipment benefits in accordance with Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to reflect the correct durable medical equipment benefits to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

12. Issue E4 concerns the following violation: Failure of the forms, in some instances, to limit the "look-back period" for medical information to five (5) years. The Respondent shall provide evidence that it revised all affected forms to reflect only a five (5) year "look-back period" to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
13. Issue E5 concerns the following violation: Failure of the forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. The Respondent shall provide evidence that it revised its forms to allow for qualified individuals to enroll in continuation coverage to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
14. Issue E6 concerns the following violation: Failure of the policy forms to provide accurate information concerning premium rate setting. The Respondent shall provide evidence that it revised all affected forms to provide accurate information concerning changes in premium rate setting to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
15. Issue E7 concerns the following violation: Failure of the forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to eliminate the requirement that congenital defects and birth abnormalities must be identified within the first twelve (12) months of life to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
16. Issue E8 concerns the following violation: Failure of the forms to provide correct information regarding changes to premium rates. The Respondent shall provide evidence that it revised all affected forms to reflect correct information regarding premium rate changes to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
17. Issue G1 concerns the following violation: Failure, in some instances, to secure and maintain signed applications or waivers of coverage for eligible employees and/or their dependents. The Respondent shall provide evidence that it revised its procedures to ensure that all waivers of

coverage and/or signed applications for eligible employees and/or their dependents are secured and maintained upon the initial issue of the small employer group, or subsequent to an employee in the waiting period at initial application becoming eligible in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

18. Issue G2 concerns the following violation: Failure, in some instances, to include the required Basic and Standard Health Benefit Plan disclosure in small group application materials. The Respondent shall provide evidence that it included the required Basic and Standard Health Benefit plan disclosure in all affected small group application materials. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
19. Issue G3 concerns the following violation: Failure to obtain the required employer provided listing of eligible dependents. The Respondent shall provide evidence that it revised its procedures to ensure that all small employer groups provide a complete listing of eligible dependents in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
20. Issue G4 concerns the following violation: Failure, in some instances, to include the small group disclosure requirements in new application materials. The Respondent shall provide evidence that it revised its procedures to ensure that all small employer group application materials contain the Small Employer Health Plan disclosure in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
21. Pursuant to § 10-1-205(3)(d), C.R.S, the Respondent shall pay a civil penalty to the Division in the amount of seven thousand and no/100 dollars (\$7,000.00). This fine represents a combined fine for the cited violations of Colorado law. This fine was calculated in accordance with Division guidelines for assessing penalties and fines, including Division bulletin no. 1-98, issued on January 1, 1998.
22. Pursuant to § 10-1-205(4)(a), C.R.S., within sixty (60) days of the date of this Order, the Respondent shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

23. Unless otherwise specified in this Order, all requirements with this Order shall be completed within thirty (30) days of the date of this Order. Respondent shall submit written evidence of compliance with all requirements to the Division within the thirty (30) day time frame, except where Respondent has already complied, as specifically noted in the Order. Copies of any rate and form filings shall be provided to the rate and forms section with evidence of the filings sent to the market conduct section. All audits shall be performed in accordance with Division guidelines. Unless otherwise specified in this Order, all audit reports must be received within ninety (90) days of the Order, with a summary of the findings, including all monetary payments to covered persons.
24. This Order shall not prevent the Division from commencing future agency action relating to conduct of the Respondent not specifically addressed in the Report, not resolved according to the terms and conditions in this Order, or occurring before or after the examination period. Failure by the Respondent to comply with the terms of this Order may result in additional actions, penalties and sanctions, as provided for by law.
25. Copies of the examination report, the Respondent's response, and this final Order will be made available to the public no earlier than thirty (30) days after the date of this Order, subject to the requirements of § 10-1-205, C.R.S.

**WHEREFORE:** It is hereby ordered that the findings and conclusions contained in the final examination report dated October 9, 2003, are hereby adopted and filed and made an official record of this office, and the above Order is hereby approved this 6th day of February, 2004.



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Doug Dean  
Commissioner of Insurance

**CERTIFICATE OF MAILING**

I hereby certify that on the 6th day of February, 2004, I deposited the within  
**FINAL AGENCY ORDER NO. O-04-141 IN THE MATTER OF THE MARKET  
CONDUCT EXAMINATION OF UNITED HEALTHCARE INSURANCE  
COMPANY**, in the United States Mail with postage affixed and addressed to:

Mr. Ronald B. Colby, President  
United Healthcare Insurance Company  
450 Columbus Blvd. 4NB  
Hartford, CT 06103

Jean Boord, Regional Compliance Director  
United Healthcare Insurance Company  
10 Cadillac Drive, Suite 200  
Brentwood, TN 37027



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Dolores Arrington, MA, AIRC  
Market Conduct Section  
Division of Insurance

**BEFORE THE DIVISION OF INSURANCE**

**STATE OF COLORADO**

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**FINAL AGENCY ORDER O-04-142**

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**IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF UNITED  
HEALTHCARE OF COLORADO, INC.,**

**Respondent**

---

**THIS MATTER** comes before the Colorado Commissioner of Insurance (the "Commissioner") as a result of a market conduct examination conducted by the Colorado Division of Insurance (the "Division") of United Healthcare of Colorado, Inc., (the "Respondent"), pursuant to §§ 10-1-201 to 207, C.R.S. The Commissioner has considered and reviewed the market conduct examination report dated October 9, 2003 (the "Report"), relevant examiner work papers, all written submissions and rebuttals, and the recommendations of staff. The Commissioner finds and orders as follows:

**FINDINGS OF FACT**

1. At all relevant times, the Respondent was licensed by the Division as a health maintenance organization.
2. In accordance with §§ 10-1-201 to 207, C.R.S., on October 9, 2003, the Division completed a market conduct examination of the Respondent. The period of examination was January 1, 2002 to December 31, 2002.
3. In scheduling the market conduct examination and in determining its nature and scope, the Commissioner considered such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, complaint analyses, underwriting and claims practices, pricing, product solicitation, policy form compliance, market share analyses, and other criteria as set forth in the most recent available edition of the examiners' handbook adopted by the National Association of Insurance Commissioners, as required by § 10-1-203(1), C.R.S.
4. In conducting the examination, the examiners observed those guidelines and procedures set forth in the most recent available edition of the examiners' handbook adopted by the National Association of Insurance Commissioners and the Colorado insurance examiners handbook. The Commissioner also employed other guidelines and procedures that he deemed appropriate, pursuant to § 10-1-204(1), C.R.S.

5. The market conduct examiners prepared a Report. The Report is comprised of only the facts appearing upon the books, records, or other documents of the Respondent, its agents or other persons examined, or as ascertained from the testimony of the Respondent's officers or agents or other persons examined concerning Respondent's affairs. The Report contains the conclusions and recommendations that the examiners find reasonably warranted based upon the facts.
6. Respondent delivered to the Division written submissions and rebuttals to the Report.
7. The Commissioner has fully considered and reviewed the Report, all of Respondent's submissions and rebuttals, and all relevant portions of the examiner's work papers.

#### **CONCLUSIONS OF LAW AND ORDER**

8. Unless expressly modified in this Final Agency Order ("Order"), the Commissioner adopts the facts, conclusions and recommendations contained in the final Report. A copy of the final Report is attached to the Order and is incorporated by reference.
9. Issue A1 concerns the following violation: Failure to correctly and completely list all applicable forms in the Colorado Annual Report of Health Coverage forms. The Respondent shall provide evidence that it revised its procedures to correctly and completely list all applicable forms in its Colorado Annual Report of Health Coverage forms to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
10. Issue E1 concerns the following violation: Failure of the forms to allow for coverage of otherwise eligible dependents who do not reside within the service area. The Respondent shall provide evidence that it revised all its affected forms to reflect the correct eligibility requirements for dependents to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
11. Issue E2 concerns the following violation: Failure of the forms to provide coverage for dental care resulting from accidents in all instances required by law. The Respondent shall provide evidence that it revised all its affected forms to modify the restrictions on dental coverage related to accidents to ensure compliance with Colorado insurance law. The

Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

12. Issue E3 concerns the following violation: Failure of the forms to provide a complete and accurate description of the required hospice care benefits. The Respondent shall provide evidence that it revised all affected forms to reflect correct hospice care benefits to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
13. Issue E4 concerns the following violation: Failure of the Standard Health Benefit Plan forms to exclude co-payments for physician ordered lab and x-ray services. The Respondent shall provide evidence that it revised all affected forms to include a correct description of the co-pay requirements for lab and x-ray services in the Standard Health Benefit Plan forms to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
14. Issue E5 concerns the following violation: Failure of the forms to provide durable medical equipment benefits in accordance with Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to reflect correct benefits for durable medical equipment to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
15. Issue E6 concerns the following violation: Failure of the forms to include the provision of complaint forms to enrollees in its complaint procedures. The Respondent shall provide evidence that it revised all affected forms to include a provision in its complaint procedures to indicate that complaint forms are provided to individuals who wish to file a written complaint to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
16. Issue E7 concerns the following violation: Failure of the forms, in some instances, to limit the "look-back period" for medical information to five (5) years as required by Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to reflect only a five (5) year "look-back period" to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
17. Issue E8 concerns the following violation: Failure of the forms, in some instances, to allow for otherwise eligible employees to enroll in continuation

coverage. The Respondent shall provide evidence that it revised its forms to allow for qualified individuals to enroll in continuation coverage to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

18. Issue E9 concerns the following violation: Failure of the forms to contain a correct definition of a disabled dependent. The Respondent shall provide evidence that it revised its forms to contain a correct definition of disabled dependent to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
19. Issue E10 concerns the following violation: Failure of the forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to provide members with notification of plan changes according to the required timeframes to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
20. Issue E11 concerns the following violation: Failure of the forms to provide accurate information concerning premium rate setting. The Respondent shall provide evidence that it revised all affected forms to provide accurate information regarding changes in premium rate setting to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
21. Issue E12 concerns the following violation: Failure of the forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law. The Respondent shall provide evidence that it revised all affected forms to eliminate the requirement that congenital defects and birth abnormalities must be identified within the first twelve (12) months of life to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
22. Issue E13 concerns the following violation: Failure of the forms to provide correct information regarding changes to premium rates. The Respondent shall provide evidence that it revised all affected forms to provide correct information regarding premium rate changes to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

23. Issue F1 concerns the following violation: Failure to include required information concerning the choice of either age-banded or composite rates. The Respondent shall provide evidence that it revised its forms to provide the required information concerning the group's right to see renewal rates quoted using either age-banded or composite rates, and to explain differences between the two methods to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
24. Issue G1 concerns the following violation: Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents in the waiting period at the time of the initial issue or renewal of the group. The Respondent shall provide evidence that it revised its procedures to ensure that all signed applications and/or waivers of coverage for eligible employees and/or their dependents are secured and maintained upon the initial issue of the small employer group, or subsequent to an employee in the waiting period at initial application becoming eligible in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
25. Issue G2 concerns the following violation: Failure, in some instances, to include the required Basic and Standard plan disclosure in small group application materials. The Respondent shall provide evidence that it revised its procedures to ensure that all new small group application materials contain the required Basic and Standard plan disclosure in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
26. Issue G3 concerns the following violation: Failure to obtain the required employer provided listing of eligible dependents. The Respondent shall provide evidence that it revised its procedures to ensure that all small employer groups provide a complete listing of eligible dependents in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
27. Issue G4 concerns the following violation: Failure, in some instances, to include the small group disclosure requirements in new application materials. The Respondent shall provide evidence that it revised its procedures to ensure that all small employer group application materials contain the Small Employer Health Plan disclosure in compliance with Colorado insurance law. The Division's records indicate that the

Respondent has complied with the corrective actions ordered concerning this violation.

28. Issue G5 concerns the following violation: Failure, in some instances, to notify the Commissioner and policyholders prior to the modification and/or discontinuation of Small Employer Group Health Benefit plans. The Respondent shall provide evidence that it revised its procedures to ensure that the Commissioner and all policyholders are notified prior to the modification and/or discontinuation of any Small Employer Group Health Benefit plans in compliance with Colorado Insurance law.
29. Issue H1 concerns the following violation: Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied. The Respondent shall provide evidence that it revised its procedures to include the required written notification to all small employers who are denied coverage to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
30. Issue H2 concerns the following violation: Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law. The Respondent shall provide evidence that it changed its procedures to ensure that groups of 2-50 eligible employees are guaranteed issuance of coverage in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
31. Issue H3 concerns the following violation: Failure to examine all applicable tax returns when determining eligibility of business groups of one. The Respondent shall provide evidence that it modified its procedures pertaining to reviewing tax documentation to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
32. Issue H4 concerns the following violation: Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups. The Respondent shall revise its procedures to ensure that a choice of the Basic or Standard Health Benefit Plans is offered to each member of the group whose policy is terminating in compliance with Colorado insurance law.
33. Issue J1 concerns the following violation: Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges. The Respondent shall provide evidence that it reviewed and modified its qualify controls to ensure that its processing staff is properly trained to request any additional information necessary to resolve

a claim, and to make appropriate decisions when all required information is present to avoid denying eligible claims in compliance with Colorado insurance law.

34. Issue J2 concerns the following violation: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law. The Respondent shall provide evidence that procedures are established to ensure that all clean electronic claims are paid, denied or settled within thirty (30) days, all clean non-electronic claims are paid, denied or settled within forty-five (45) days and all claims except where fraud is involved, are paid, denied or settled within ninety (90) days in compliance with Colorado insurance law.
35. Issue J3 concerns the following violation: Failure, in some instances, to pay interest and/or penalties on claims that were not paid or settled within the time periods required by Colorado insurance law. The Respondent shall provide evidence that it revised its procedures to ensure that interest and/or penalties are paid on claims not paid within the time periods required by Colorado insurance law. Respondent shall perform a self-audit and pay any interest and/or penalties due on claims that were not paid or settled as they relate to this violation for the time period beginning January 1, 2002 through January 30, 2004. Respondent shall submit a summary of the findings to the Division on or before May 6, 2004.
36. Issue J4 concerns the following violation: Failure, in some instances, to process claims accurately. The Respondent shall provide evidence that it reviewed and modified its claims processing quality control procedures to ensure that all claims are investigated properly to determine proper allocation of benefits and to eliminate unnecessary delays in payment in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
37. Issue K1 concerns the following violation: Failure, in some instances, to make utilization review determinations and provide required notifications within the timeframes as allowed under Colorado insurance law. The Respondent shall provide evidence that it revised its procedures to ensure that the timeframes for determination and notification of utilization review decisions are in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
38. Issue K2 concerns the following violation: Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals. The Respondent shall provide evidence that it revised its

utilization review approval procedures to ensure that the notification sent to members is in compliance with Colorado insurance law.

39. Issue K3 concerns the following violation: Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days. The Respondent shall provide evidence that it revised its procedures to ensure that written notification of first level appeal decisions is completed within the twenty (20) working day timeframe in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
40. Issue K4 concerns the following violation: Failure, in some instances, to include all required components in first level appeal determination letters. The Respondent shall provide evidence that it revised its procedures to ensure that first level appeal determination letters contain all the information required in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
41. Issue K5 concerns the following violation: Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination. The Respondent shall provide evidence that it revised its first level appeal review procedures to ensure physicians who review these appeals were not involved in the initial adverse determination in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
42. Issue K6 concerns the following violation: Failure, in some instances, to notify members fifteen (15) days in advance of the hearing date for second level appeals. The Respondent shall provide evidence that it revised its second level appeal review procedures to provide notice of second level appeal hearings to ensure compliance with Colorado insurance law, or if ERISA notice requirements conflict with Colorado insurance law, to comply with Federal law.
43. Issue K7 concerns the following violation: Failure, in some instances, to ensure that second level appeal panels include a majority of health care professionals with appropriate expertise to review the case. The Respondent shall provide evidence that it revised its second level appeal panels' review procedures to include a majority of health care professionals with appropriate expertise to review the case to ensure compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.

44. Issue K8 concerns the following violation: Failure to include all the required elements in written notifications of second level appeal rights. The Respondent shall provide evidence that it revised its procedures to ensure that all second level appeal notifications disclose all mandated rights of the person initiating the appeal in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
45. Issue K9 concerns the following violation: Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determination. The Respondent shall provide evidence that it revised its procedures to ensure that second level appeal notifications include all the required elements pertaining to the appeal decision and the person's right to an external review in compliance with Colorado insurance law. The Division's records indicate that the Respondent has complied with the corrective actions ordered concerning this violation.
46. Pursuant to § 10-1-205(3)(d), C.R.S, the Respondent shall pay a civil penalty to the Division in the amount of thirty-three thousand five hundred and no/100 dollars (\$33,500.00). This fine represents a combined fine for the cited violations of Colorado law. This fine was calculated in accordance with Division guidelines for assessing penalties and fines, including Division bulletin no. 1-98, issued on January 1, 1998.
47. Pursuant to § 10-1-205(4)(a), C.R.S., within sixty (60) days of the date of this Order, the Respondent shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.
48. Unless otherwise specified in this Order, all requirements with this Order shall be completed within thirty (30) days of the date of this Order. Respondent shall submit written evidence of compliance with all requirements to the Division within the thirty (30) day time frame, except where Respondent has already complied, as specifically noted in the Order. Copies of any rate and form filings shall be provided to the rate and forms section with evidence of the filings sent to the market conduct section. All audits shall be performed in accordance with Division guidelines. Unless otherwise specified in this Order, all audit reports must be received within ninety (90) days of the Order, with a summary of the findings, including all monetary payments to covered persons.
49. This Order shall not prevent the Division from commencing future agency action relating to conduct of the Respondent not specifically addressed in

the Report, not resolved according to the terms and conditions in this Order, or occurring before or after the examination period. Failure by the Respondent to comply with the terms of this Order may result in additional actions, penalties and sanctions, as provided for by law.

50. Copies of the examination report, the Respondent's response, and this final Order will be made available to the public no earlier than thirty (30) days after the date of this Order, subject to the requirements of § 10-1-205, C.R.S.

**WHEREFORE:** It is hereby ordered that the findings and conclusions contained in the final examination report dated October 9, 2003, are hereby adopted and filed and made an official record of this office, and the above Order is hereby approved this 6th day of February, 2004.

A handwritten signature in cursive script that reads "Doug Dean".

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Doug Dean  
Commissioner of Insurance

**CERTIFICATE OF MAILING**

I hereby certify that on the 6th day of February, 2004, I deposited the within  
**FINAL AGENCY ORDER NO. O-04-142 IN THE MATTER OF THE MARKET  
CONDUCT EXAMINATION OF UNITED HEALTHCARE OF COLORADO, INC.,**  
in the United States Mail with postage affixed and addressed to:

Mr. Victor Lazzaro, President  
United Healthcare of Colorado, Inc.  
8051 East Maplewood Avenue, Suite 300  
Greenwood Village, CO 80111

Jean Boord, Regional Compliance Director  
United Healthcare of Colorado, Inc.  
10 Cadillac Drive, Suite 200  
Brentwood, TN 37027



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Dolores Arrington, MA, AIRC  
Market Conduct Section  
Division of Insurance